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ORIGINAL DEPARTMENT.

CLINICAL LECTURE.

EPILEPSY, SUDDEN DEATH IN A COMATOSE CONDITION, NO LESION DISCOVERED AT THE AUTOPSY. — INFLAMMATION OF APPENDIX VERMIFORMIS, FOLLOWED SEVEN MONTHS LATER BY ULCERATION, RUPTURE AND DEATH.

A Clinical Lecture delivered at the Hospital of the University of Pennsylvania by WILLIAM PEPPER, M.D., LL.D., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WILLIAM H. MORRISON, M.D.

GENTLEMEN: I wish in the first place to call your attention to these specimens which were removed from a case which has lately died in the hospital. The patient was an epileptic. He had been subjected to various methods of treatment, and was admitted to the hospital with the hope of benefiting him, if that were possible. He had epilepsy very badly. The attacks occurred four or five times a day, and were increasing in severity. The patient's mind was failing under the influence of the disease. As I have already said he had been treated in all ways, but at no time had he been benefitted. He was unable to work, and was becoming more and more feeble-minded. The patient was before you on one occasion, and at that time I said that occasionally in cases of this kind, where the ordinary measures of treatment fail to arrest the attack, by a course of

treatment which would produce a radical and profound effect upon the whole nutrition, there would be a change in the symptoms. We therefore proposed to put the man to bed, and keep him there for a long time, and to place him upon a carefully restricted diet, gradually reducing it so as to effect as far as possible a complete revolution and a re-creation of the entire frame. We placed him in bed and gave him moderate doses of antipyrine, the influence of which over vaso-motor phenomena would indicate that it might be serviceable. He was given eight grains of antipyrine three times a day. I am sorry to say that this proved of very little service. The man was very rebellious as regards diet, so that practically we were unable to restrict his food. He was willing to lie in bed as long as he was well fed, and the fact is that he increased in weight while under treatment. As the man lay in bed he looked in perfect health, with no sign of depression or debility about him, and this continued until very shortly before his death.

The use of antipyrine was begun on October 2, and continued until October 13. As it accomplished nothing it was stopped, and antifebrin in three grain doses, three times a day, was substituted. As the convulsions still continued severe, he was placed upon a preparation of the bromides, containing five grains each of the bromides of potassium, sodium, and ammonium, with fifteen drops of hydrobromic acid, three times a day. This was given in conjunction with the antifebrin. The paroxysms were not materially influenced, and the antifebrin was cautiously increased until eight grains

were given three times a day. Under this treatment the convulsions steadily decreased in number, so that from October 21 to November 3, a period of two weeks, he only had twelve convulsions; whereas, during the previous two weeks, he had had twenty-one attacks.

On November 1, the antifebrin was reduced to two doses a day, and the bromide mixture was only given twice a day. The man remained quiet in bed, and continued to do well. On the morning of November 3, he attempted to rise from bed for some purpose, and fell back unconscious, and continued unconscious from this time until his death, sixteen hours later. He was in a condition of complete coma, with stertorous breathing, and for the first time since his admission, with but one exception, there was a rise of temperature, from 98.5° in the morning to 102° in the evening, and at the time of his death it was still rising. Upon one other occasion he had had for a short time a temperature of 101.2° , apparently due to some temporary disturbance. Since his death his wife informs me that on four previous occasions this man had suddenly passed into an unconscious condition, and continued in this state for twenty-four hours. It was thought on each occasion that he would die, but he had gradually regained consciousness, and recovered his usual health.

A careful post-mortem examination was made. What should we expect to find in such a case? We are to remember that here we had a man who had for a long time suffered with convulsions which had been increasing in frequency and severity, and that he complained a great deal of headache. When we came to ask ourselves the question whether or not there was some intra-cranial disease or tumor which might cause both the convulsions and the headache, the answer was in the negative. There was no history of syphilis or of traumatism. The ophthalmoscopic examination was negative. There was no paralysis of any cranial nerve. There was nothing to point to lesion within the cranium as the cause of the trouble. There was no lesion of the kidneys, nor of the spleen. We therefore came to regard the case as one of essential epilepsy. Yet when I heard that the man had fallen into this unconscious state, not knowing at that time that he had had previous similar attacks, I naturally suspected that there would be found some aneurism or other intra-cranial lesion. The results of the post-mortem examination were entirely negative.

No lesion was found anywhere to explain this sudden death. There was no heart-clot, no slight effusion, no small hemorrhage; nor does the mode of death throw much light upon its cause. The patient did not die from paralysis of the heart, and this is an important thing to note. The heart remained strong to the very last, and he evidently died by the brain, the respiration and the circulation continuing good to the very end.

You will at once see that I dwell upon these facts in consequence of the remedies which this man had taken, for in any given case the question must arise whether or not the drugs which have been administered could have caused the sudden death. This is particularly true when we have been giving such drugs as antipyrine and antifebrin, which if pushed beyond a certain limit do exert a depressing influence upon the heart. Cases are beginning to accumulate in the journals in which the use of large doses of these drugs has been attended with symptoms of cardiac failure and of failing circulation. You will see that in this case we can scarcely assign to these drugs any part in the event. In the first place, at no time did he take a dose which would be sufficient to depress the heart and circulation. He was a strong, muscular man, with a healthy heart; further, he was lying in bed making no muscular exertion. At no time did the dose exceed eight grains of antifebrin three times a day. This may be said to be a perfectly safe dose under the circumstances. While taking it three times a day he bore it perfectly. Since November he took it only twice a day. Finally, in the events of the day, there was not the slightest evidence of depression of the heart or of the circulation. The symptoms were not those of cardiac failure, but those of sudden paralysis of the brain, a sudden cessation of nervous action, unconsciousness, profound coma and gradual failure of cerebral power. We may, therefore, say that neither the bromide, the antipyrine, nor the antifebrin had any influence in the production of the fatal result. It is important to dwell upon this because we desire to learn what are the limits of safety of these drugs. It is proper that we should scrutinise every case where new drugs are given, and where such a dramatic end occurs, to see if the drugs have had any part in the production of the result.

There are many chronic diseases in which sudden death occurs. It may take place in Addison's disease from heart failure under exertion. In the same way, sudden death

may occur in leucæmia from the watery state of the blood and the exhausted condition of the heart. In other cases, sudden death occurs from the development of some constitutional condition of a highly complex character, as we see sometimes in diabetes. At times, a patient with diabetes, who has apparently been doing well, will suddenly become delirious, pass into a condition of coma, with rapid rise of temperature, and die within twenty-four hours. This mode of dying is far from rare in diabetes, but it has not yet received a satisfactory explanation. It is clear that there is developed some highly complicated product of nutrition, which, acting upon the nervous system, causes death as does the ingestion of some fatal poison. A perfectly satisfactory explanation of these cases of sudden death has not yet been found. You will observe that in this case, the patient died with a rapid rise of temperature and with symptoms of arrest of the circulation of the brain. This man did not die from the effort to rise in bed. This was not a syncopal attack from failure of the heart. The probability is that he attempted to rise from bed because he felt uncomfortable and was overcome by the unconsciousness before he could get on his feet. This has occurred from some profound nutritional change associated with a morbid vaso-motor state in which failure of the cerebral circulation occurred with complete unconsciousness, attended with derangement of nutrition throughout the body, marked by fever, excited circulation, continued unconsciousness, coma and rapid death. We cannot explain it. No gross lesion presents itself.

Observe that he had four preceding similar attacks, all of the same nature. He was in all suddenly seized with unconsciousness and coma, apparently going to end in death, but out of which he rallied. This case is of interest in many ways; of interest from the fact that these new and powerful drugs had been administered, but they cannot be held in the least responsible for the result. It is also of interest, because we have here a case of sudden death in which careful examination fails to reveal a satisfactory explanation.

Inflammation of the Appendix Vermiformis, Followed Seven Months Later by Ulceration, Rupture and Death.

Very different are the other specimens which I have to exhibit. These were removed from the body of a young man 18 years of age, whom I attended last March, with an attack of acute obstruction of the bowels.

The obstruction was absolute and was marked by severe pain a little to the right of the median line and low down toward the hypogastrium. The fever was moderate. The belly was distended, and there was tenderness on pressure, which was more marked in the region above-mentioned than at any other point. There was no distinct indurated mass to be made out in any position. The diagnosis was circumscribed acute peritonitis, with accumulation in the bowel close to the cæcum. It is not difficult to see why this diagnosis was formed. The patient was rather too old for intussusception of the bowel, and this accident is usually attended with a demonstrable fullness and hardness in some part, and there is not the rapid development of peritonitis that occurred in this case. Moreover, in this case, vomiting was not so urgent as it becomes in intussusception, where it is frequently repeated, and if the obstruction is not relieved, soon becomes fecal. Examination by the rectum failed to reveal anything. When the intussusception is extensive, it is not uncommon to feel the volvulus when a rectal examination is made, and often a little bloody mucus escapes. The symptoms of intussusception were therefore wanting in this case.

It was not a case of ordinary impaction of the bowel. There was no demonstrable mass, and the symptoms of inflammation were too marked and came on too abruptly. The pain was also too severe. Nothing would explain it but peritonitis. The inflammation was not associated with typhlitis or perityphlitis, for there was no induration, and the position of the pain was more toward the median line than it would be if the inflammation were located in the cæcum. In perityphlitis, we find in the region of the cæcum an area of distinct hardening, with sometimes a slight prominence. This was wholly wanting in this case. We feared at the time that the appendix vermiformis might be involved in the inflammation. It could not be felt by a rectal examination.

The patient was kept in bed and quinine and opium given by the rectum. Minute doses (one-twelfth of a grain) of calomel were given by the mouth, simply placed dry upon the tongue, but not a drop of water or a particle of food was given for several days. Little pieces of ice were allowed to melt in the mouth, but opium was depended upon to blunt the sensation of thirst. He remained in this condition for nine days without passing even flatus by the bowel. Then flatus was passed, and on the tenth day an enema secured a movement, and after that

convalescence was rapid and apparently complete.

It was therefore evident that whatever had been the cause of the obstruction it had ceased to exist. The lad continued perfectly well all summer, spending his vacation in hunting and fishing. In the fall he returned to his duties apparently in perfect health. Ten days ago, he was suddenly seized with agonizing pain referred to the lower zone of the abdomen. The pain was so severe that he rolled and writhed on the floor, and four large hypodermic injections of morphia were given before any relief was obtained, but at no time during the whole of his illness could a sufficient amount of opium be given to entirely relieve his suffering. There was an immediate and progressive rise of temperature. It gradually rose, and when I saw him in consultation, four days after the onset of the pain, it was 104.6° , and on the following night it was 107.5° . There was with this a corresponding increase in the rapidity of the pulse which became running and small. Vomiting was not frequent: it occurred once or twice in the beginning; the stomach then became quiet, but the vomiting recurred once or twice toward the close of the case. At no time was the vomiting such as we have in mechanical obstruction of the bowel. Nothing like fecal matter was vomited, yet from the time that he was taken, until his death, no flatus passed through the intestine. The bowels became rapidly distended, and the colon and the coils of the intestine could be distinctly seen through the stretched abdominal walls. The urine was secreted freely and was perfectly normal. It was passed frequently owing to the irritation of the bladder. I at once made an examination of the rectum. The bowel was entirely empty, and the roof of the pelvis was found to be uniformly hard, instead of soft and yielding.

The question of diagnosis again arose, and it was impossible not to connect this second attack of acute peritonitis and obstruction of the bowels with the previous one. This made it the more certain that the first attack had not been one of intussusception. If it had been, it would not have recurred. It was not a case of impaction, for the symptoms were too sudden and too violent. It was not a case of typhlitis, for there was no local induration. Rectal examination showed no greater fullness on the right side than on the left. It was possible that in the former attack there had occurred, between two inflamed coils of intestines, a band of organized lymph which had become

stretched, and that a portion of the intestine had passed into this loop and become strangulated, thus causing an internal hernia. I have seen this accident occur on several occasions. In opposition to such a view was the fact that the peritonitis was immediate and severe, and had almost at once followed the attack of sudden pain. Had this been a case of mechanical obstruction, the symptoms of peritonitis would have appeared more gradually. Again, as I have already pointed out, the vomiting was not such as accompanies mechanical obstruction. It did not recur frequently, and at no time were any of the contents of the bowel brought up. All these things were against the view of an internal hernia.

It therefore appeared probable that the portion of the bowel which had been involved in the previous attack of inflammation had now perforated, and that general peritonitis had followed. Your studies in pathology will teach you that such perforation most frequently has its seat in the appendix vermiformis; so that this attack naturally connected itself with the explanation of the attack of last spring.

The question of laparotomy was seriously discussed, but it was clear that the peritonitis was so intense that the operation was inadmissible. Death occurred at the end of the fifth day of the attack.

The autopsy was made twenty-four hours after death. I have in my hand a coil of the intestine, showing the character of the peritonitis. There is a thick layer of yellow lymph, looking like buckskin, covering the intestines. The abdomen also contains pus and serum. The intestines were everywhere matted together, forming little pockets, containing pus and serum. The peritonitis was especially intense in the pelvic segment. At the point where the pain had been so intense last spring, there was a cluster of coils of intestine strongly adherent. So close were these adhesions that some of them evidently dated back to the first attack. In addition, there were other adhesions resulting from the recent inflammation. The vermiform appendix was covered by a cap of adherent intestines. It was purplish in color, was distended and swollen. Close to the cæcum it was nearly severed by gangrenous ulceration. There was a perforation into which the thumb could be placed. The mucous membrane of the appendix was rough and thickened. The opening of the appendix into the cæcum had been completely closed by the previous inflammation. The pus from this perforation had in conse-

quence of the dense adhesions around the appendix burrowed in different directions, and there was no circumscribed collection of fluid at the site of perforation.

Here, then, we had had a case of simple appendicitis last spring, with peritonitis, gradually terminating by resolution, leaving adhesions. The appendix, however, remained inflamed, but producing no symptom, and gradually went on to ulceration and rupture. Careful search was made for any concretion that might be present, but none was found.

This case of perforating appendicitis is of special interest. It is almost unique in the fact that it clearly followed upon an attack of simple inflammation of the appendix, and it warns us how careful we should be in the after treatment of any case of inflammation in the cæcal region. It is perfectly true that in the present instance nothing was left undone that suggested itself as desirable. I do not see how it would have been possible to have anticipated, or to have averted the fatal result. This case impresses upon us most strongly the fact that in these cases of disease of the appendix there is nearly always, if not always, a pre-existing, insidious, unsuspected inflammation. There may be a little catarrh of the lining membrane of the appendix, which does not reveal itself by any symptom. There may be an occasional slight twinge of pain, which does not attract special attention. There may be gradually forming a little concretion, which will kill the person in twenty-four hours. The concretion gradually increases in size, until its irritation leads to ulceration and perforation; giving rise to violent pain and severe peritonitis, which is one of the most rapidly fatal forms of peritonitis with which we meet.

This catarrhal inflammation of the appendix may come from wrenches, from strains, or from over-exertion. In the case which I have described there is reason to think that the starting point of the inflammation was violent over-exertion and over-heating in base ball. This acute inflammation once started, may run into the chronic form, ending in perforation. During the progress of the chronic inflammation, a concretion forms varying in size from a very small body up to a cherry stone or a date seed. This sometimes is made up of dried mucus, or it may have as a nucleus a small seed or other foreign body which has found its way into the appendix. You will observe that in this case the opening into the cæcum had been closed by inflammation. This, of course,

formed a closed abscess. The presence of pus and decomposing matters would naturally excite inflammation and a tendency to perforation.

In the treatment of such a case as this, it is perfectly clear that there is only one thing that will give the patient a chance, and that is instant laparotomy; but how are you to assume the responsibility of opening the abdomen in such a case within a few hours of the commencement of the attack? And how will you be able to convince the family that what seems like an ordinary colic, is a deadly disease which can only be met by one of the most dangerous operations in surgery? You can not be sure of your diagnosis, and even when you have good reasons for suspecting this accident, you can not demonstrate it. For these reasons, I fear that we shall never be able to perform laparotomy early enough to save our cases of perforating appendicitis. The only thing to be done is to open the abdomen within twelve hours, locate the appendix, ligate it with antiseptic ligatures, remove the distal portion, and introduce a drainage tube, or if the ulceration is so close to the cæcum as to preclude the use of the ligature, make a fæcal fistula.

The general symptoms are not sufficient to enable you to recognize the trouble. The pain may be more marked on the right side, but it spreads to other parts of the abdomen and the symptoms of peritonitis soon become general.

One of the cases of perforation of the appendix, which I attended during this summer, was in a young man who was believed to have been in perfect health, until the beginning of his last illness, which terminated fatally within seventy-two hours. A neighbor's house catching fire, he went to afford what assistance he could, wrenched himself in the side and had some pain. The next day symptoms of peritonitis appeared, and I saw him thirty-six hours after the accident. I considered it a case of perforating appendicitis and suggested laparotomy. It was agreed that if the patient were no better, the operation should be performed the following morning. The operation was performed, and the drainage tube was passed into a cavity full of pus. It was then supposed that the case was one of perityphlitis. The patient, however, died, and at the autopsy the appendix was found in a state of gangrene, with the evidences of old catarrhal inflammation which had been there for months. This is only one of a number of cases which I have seen. In

this case the operation was done within sixty-four hours after the onset of the symptoms, and this has been the earliest that I have ever been able to have the operation performed.

One of the most important diagnostic measures in these cases is the rectal examination, and in no cases where a trouble of this kind is suspected should the rectal examination be postponed one hour, but, on the other hand, it should be frequently repeated. The moment that, by rectal exploration, we are able to detect the slightest fullness in the cæcal region, laparotomy should be performed. In the case from which these specimens were removed, a rectal examination within eighteen hours of death failed to reveal any difference between the two sides. The reason of this is evident, for the adhesions were so dense as to prevent any accumulation of pus.

COMMUNICATIONS.

IMPROVED SPLINT.

BY D. BENJAMIN, M.D.,

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This splint, called the "Day Splint," with double inclined plane, has been in use in hospitals and private practice for many years, and is considered by many surgeons the best splint that can be used for fractures of the lower extremities. It has some advantages, viz.: In treating compound fractures it will permit the surgeon at all times to inspect the injuries to the soft parts, as they can be treated on this splint without bandaging. It also has the advantage of the hinge at the apex of the frame, under the knee, which permits the passive movement of the joint, without permitting the movement of the fragments of fractured bones.

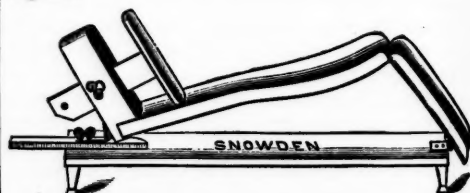
The mechanical principles upon which it is constructed are correct, but the methods used in its construction are defective. The splint would, no doubt, be more extensively used were certain objections and imperfections in its mechanism overcome. In the first place, there are no adequate means of keeping the heel of the splint in the notches, and it has been the experience of every surgeon who has used it that, notwithstanding the most careful tying, it will frequently slip out, letting the leg suddenly down straight, thereby bruising and deranging the ends of the bones.

The second objection is that the movable foot piece does not come down low enough towards the bottom of the heel, to make traction in the line of the long bones, but makes its traction upon the foot, about opposite the ball of the big toe, thereby bending the ankle unnecessarily and uncomfortably, and producing inefficient traction.

Objection third: That the foot piece wobbles from side to side, and unless great care is used in managing the screws, would be so loose as to cause a rolling of the foot and, consequently, an irritation of the wounds, and a rotation of the lower fragments of the bone on the upper fragments, interfering with the union of the parts.

Objection fourth: That the movable foot piece is straight up and down, whereas the natural position of the foot is with the toes turned slightly outward.

Objection fifth: That as the foot settles down towards the foot piece, after being adjusted, the traction ceases until the screws are turned at the next visit of the physician. In using this splint I have been constantly troubled by these objectionable features, and I have therefore attempted to overcome them in the manner illustrated in the accompanying cut.



The first objection is overcome by a plate of iron with a long slot occupying the position of the notches, and another plate of iron, hinged, is screwed to the base of the permanent foot piece. This latter plate is provided with a bolt and thumb-screw, passing through the slot in the first plate, preventing the possibility of the foot piece slipping in any way, and also having the additional advantage of being adjustable at any distance or angle required; in other words, of increasing or diminishing the angle at pleasure with perfect firmness and safety, and no danger whatever of its slipping.

The second objection is overcome by placing the foot piece lower down towards the heel.

The third objection is overcome by fastening the foot piece to a solid bar, two inches in width, and three-quarters of an inch in thickness, which slips through a mortise in the immovable foot piece, entirely prevent-

ing any wobbling of the foot piece. This bar can be fixed in any position by means of the thumb-screw on the side.

The fourth objection is overcome by making the foot piece on the bar adjustable for either the right or left foot, so as to give the foot its natural eversion.

The fifth objection is overcome by allowing the thumb-screw in the side of the permanent foot piece to be loosened, and a weight attached to the bar, and hung over the foot of the bed, keeping up a constant traction, until the surgeon sees fit to fix the movable foot piece by means of the thumb-screw, in any desired position.

GLEDITSCHINE.

BY WILLARD H. MORSE, M.D.,
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BOTANICAL NAME.—*Gleditschia Triacanthos*.

Synonyms:—*G. spinosa*, Marshall, *arbutum*, 54; *G. meliloba*, Walter, fl. car., 254; *G. macrantha*, Willdenow, Baumz., 164; *G. elegans*, Salisbury, prodr., 323; *Melilobus heterophylla*. Honey locust; black locust; sweet locust; tear-blanket; honey chucks; three-thorned acacia.

BOTANICAL DETAILS.—Natural order of the leguminosæ; genus: *gleditschia*.

FAMILY RELATIONS.—*Prosopis pubescens*; *dalea spinosa*; *eysenhardtia orthocarpa*; *robinia viscosa*, *R. pseudo-acacia*, *R. neo-mexicana*; *oleya tesota*; *piscidia erythrina*; *cladrastis tinctoria*; *sophora secundiflora*, *S. affinis*; *gymnocladus canadensis*, *G. monosperma*; *parkinsonia torreyana*, *P. microphylla*, *P. aculeata*; *cercis canadensis*, *C. reniformis*; *prosopis juliflora*, *P. pubescens*; *leucena glauca*, *L. pulverulenta*; *acacia Wrightii*, *A. Greggii*, *A. Berlandieri*; *lysiloma latisiliqua*; and *pithecolobium unguisati*.

GENERIC SYNONYMS.—*Prosopis juliflora* is also known as "honey locust"; *robinia pseudo-acacia* as "black locust"; *robinia pseudo-acacia* and *robinia neo-mexicana* as "locust"; and *prosopis juliflora* as "honey shucks."

REMARKS ON RELATIONSHIP.—It is notable that *piscidia erythema* is co-related. *Robinia pseudo-acacia*, and *acacia wrightii* *seu stenocarpa*, have by some been confounded with *gleditschia triacanthos*; but they are not identical. Linnaeus, Gaertner, and some others have sought to make *gleditschia triacanthos* a variety of *gymnocladus monosperma*; but it has been fully proven that the two are distinct. *Gymnocladus monosperma* has a short pod, containing but one seed, while *gleditschia triacanthos* has a long pod with several seeds. There are four or five of the

gleditschia; but these two are the only American species.

DESCRIPTIVE BOTANY.—Flowers polygamous; calyx short, $\frac{3}{8}$ cleft; lobes divergent; petals and espals of same number; stamens, $\frac{3}{8}$ distinct, inserted with petals on base of calyx; legume, flat, pulpy; seeds 8 to 15, flat; flowers and pods, both greenish; leaves, pinnate; thorns above the axils, stout, often compound or triple. The pods are generally 8 to 10 inches long, and twisted; the thorns (or spines), average an inch in length; the wood is heavy, hard, coarse-grained, durable, susceptible of high polish, layers marked by open ducts; medullary rays numerous; color, reddish-brown; sp. gr., 0.6740; ash, 0.80. The wood is valued for fence-posts, wagon-hubs, well-curbs, construction, etc. Dr. Porcher informs us that the pods are used, in Georgia, in brewing beer. Children, as well as swine and sheep, eat the pulpy pods, without unpleasant after-effects; but, like the persimmon, they are not considered edible till frost-bitten. Presumably, like the European locust (*ceratonia siliqua*), the pods might be made into a syrup and spirit.

HABITAT.—From western Massachusetts to the Brazos river in Texas, in the Atlantic and Gulf States, on the western slopes of the Alleghanies; west through southern Michigan, to about longitude 96° west: the only section within this area, where it has not been found, is eastern Florida. It is the characteristic tree of the "barrens" of middle Kentucky and Tennessee, and reaches its greatest development in the bottoms of the Ohio and Sangamon. It is quite as common in the dry, sterile hill-country as in the rich and fertile bottoms. In the east, while not indigenous, it has been naturalized so thoroughly as to be accounted an agricultural pest in some sections where it was originally introduced as a shade tree. It grows very rapidly, attaining a height of from twenty-five to forty-five feet.

SUB-VARIETIES.—There are two sub-varieties, viz: *Gleditschia inermis*, which is almost entirely destitute of thorns, and *G. brachycarpus*, which has the thorns and pods abbreviated, and the former white and unbranched. This latter sub-variety is the common wild locust of Mississippi and Louisiana, and is not clearly distinguished from the *acacia farnesiana* and *A. stenocarpa*. The flowers are very inconspicuous. The peculiarity about this form is that on cultivation the pods and flowers are more developed, and the spines become of the color of the

bark, as well as bifid and compound. Another characteristic is its exemption from the attacks of the locust-borer (*cyllene picta*). All trees with spines, even the thorn-apple, growing in the lower Mississippi valley, are locally called "tear-blankets." It is worthy of mention, perhaps, that the *gleditschia brachycarpus* does not afford spines long and strong enough for the Mexican Indians to use as "needles and pins." The leaves of this sub-variety are not deciduous—a fact sufficient to prevent confounding it with the *acaciæ*.

PARTICULAR MEDICINAL NOMINATION.—While the alkaloid *gleditschine* is afforded by the leaves of the *G. triacanthos* and both of its sub-varieties, it is found in the largest amount in the winter leaves of the *G. brachycarpus*, which is better distinguished by De Candolle as the *G. brachycarpa*.

MEDICINAL PORTION.—The leaves, and the alkaloid derivable from them. The bark of the root is said to be "very active;" but no particular inquiry has been made as to its properties. The pods when eaten are inert; but it is claimed that there are those who are "intoxicated" to some extent by eating them.

CHEMICAL COMPOSITION.—The earliest chemical inquiry related to the pods, the pulp of which was found to abound in albumen. The pod itself is also productive of gluten. As remarked above, it is altogether probable that from the honey-like juice a spirituous liquor is distillable. And it is quite as equally probable that a toxic bitter (?) principle resides in the bark of the root. The leaves contain a peculiar alkaloid, well-termed *gleditschine*, and inappropriately styled "stenocarpine." Seward is authority for the statement that the winter leaves contain $7\frac{1}{2}$ grains to every ten pounds, while the summer leaves contain only 5 grains to the same amount of leaves. My own investigations lead me to believe that it is easy to obtain one grain from every 100,000 grs., and frequently one from 60,000 to 80,000! This applies to the green leaves, the dried leaves responding to analysis "with difficulty." It is yielded up to both water and alcohol, and most freely to the latter. Unfortunately, the alkaloid is not readily crystallizable, but occurs as a semi-liquid mass of a greenish tint. United with acids it forms greenish-white salts, tasteless, and apt to assume the form of four-sided prisms. Possibly the sulphate of *gleditschia* will take the lead in subsequent therapeutical consideration.

Perhaps as good a method of alkaloid determination as any consists in first preparing

an alcoholic extract by the usual course of operation. This is treated with acidulated distilled water at about 110° F., a little animal charcoal being added. After filtration, and partial neutralization with ammonia, a fresh concentrated infusion of galls is slowly added until precipitation ceases. After decanting and washing, this precipitate is rubbed up with about one-fourth its own weight of pulverized litharge. An alcoholic solution is then had, and, after filtration and evaporation, the residue is twice acted on with cold and very pure sulphuric ether, which removes impurities and leaves the *gleditschine*. The action of potassa upon an aqueous infusion of an alcoholic extract of the leaves, will also result in the isolation of the alkaloid, showing that the same result may be had either by crude or elaborate means.

Of the properties of *gleditschine*, I can only say that it is soluble in both cold and hot water, and in ether and volatile oils. It has the peculiarity of frothing on agitation. It is fusible, and combines with several salifiable bases. From the first, I could not obtain as favorable results from my privately-isolated alkaloid as from that of Lehn & Fink, in solution. Indeed, it was all but impossible to obtain any mydriasis from the alkaloid, which I was able to obtain after toilsome laboratory effort. Still in doubt, the following manometric experiments were tried:

1. The effect of atropine on the eye of a curarized rabbit, was a slow depression of the intra-ocular tension.
2. The effect of cocaine was at first a slight elevation of tension, followed by a decrease, less than one-half that of atropine.
3. Lehn & Fink's "*gleditschine*" first largely increased the tension, and then diminished it to an extent less than the increase.
4. A combined atropine-cocaine solution had an effect similar to the "*gleditschine*," except that the after-diminution of tension exceeded the increase.
5. The effect of a compound solution of cocaine, 1 to 5; atropine, 1 to 2; and *gleditschine*, 1 to 2, was the same as that of "*gleditschine*."
6. The effect of my poor alkaloid, "all alone," was, first, great fluctuation in ocular tension, followed by a barely-appreciable depression.

In addition to this, let me add that by atropine, cocaine, and "*gleditschine*," I gain no effect on the corneal curvature, while, from my lonely alkaloid I get a short-

tening of the curvature, like that from weak pilocarpine or eserine.

Moreover, as above observed, the true alkaloid is apt to crystallize in four-sided prisms, while the "gleditschine" crystallizes in acicular (cocaine-like) form. I cannot understand this, and will only remark that the latter are, if not actually like those of cocaine, very similar to atropine and cocaine, well mixed and shaken together. To my mind, there are two or three alkaloids in the "gleditschine;" at any rate, it is more than equivalent to a two per cent solution.

CONCLUSIONS.—With the leaves of *gleditschia tricanthos*, I am unable to make such a poultice as Dr. Claiborne nominates. My horses, after wearing the poultice, are as prone to kick as ever when the part is incised. It is told of the editor of a sensational New York daily that when he has a rich, blood-and-thunder article "written up," he directs that it be "located away off down South in some out-of-the-way place." The beauty about locating that poultice in West Feliciana Parish, La., is, that it is an out-of-the-way country of large area, and that by the time its substantiation could be sought out, the bubble might burst.

With the alkaloid, I am unable to obtain any of the results recited by Claiborne, Seward, Jackson, Mitchell, Knapp, or any other. More than this, I am willing to challenge any chemist to procure such substantiation. The results can be procured by "gleditschine," and by a compound solution of atropine-cocaine, with a small quantity of eserine, or of true *gleditschine*. *They cannot be procured by the true alkaloid.*

I assure Dr. Thompson (*Vide Medical Age*, Oct. 25) that the leaves of this tree (which I have taken so much pains to study) will actually produce an alkaloid; but it is the mountain laboring and bringing forth a mouse. This alkaloid, when obtained, will show certain peculiar properties, but among them the mydriatic and anæsthetic are nil.

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HYPNOTISM AND ITS CURATIVE USES.

BY HERMAN B. ALLYN, M.D.,
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Hypnotism, and the wonderful therapeutic results which have been asserted to follow its employment, have aroused such widespread interest and discussion among Continental physicians, that a breif *résumé* of the subject will probably be of interest to many readers of the REPORTER. Its history is briefly as follows:

In 1840, Braid, of Manchester, England, an enthusiast in animal magnetism, discovered that in most persons on whom he tried the experiment, he could produce a condition of sleep by getting them to look steadily at a fixed object, about a foot distant from their faces and slightly above the level of their eyes. The condition thus developed he called hypnotism. His discovery was a development in the line of animal magnetism, and aroused much interest in England and France. During the early part of the decade from 1850 to 1860, lectures upon hypnotism—then commonly called "biology"—were

frequently given in the various towns and cities of the United States.

In 1860, Liébault, of Nancy, published his book on "Sleep and the Conditions Analogous to It."¹ In this book he maintained that the most essential thing in hypnotism was the suggestion of thoughts to the patient while asleep, and argued that hypnotism was simply a modification of normal sleep in which direction was given to the dreamer's ideas by another person. Liébault's work attracted comparatively little attention until the publication of the book of Bernheim,² which contained new experiments and a keen and thoughtful criticism of the ground previously covered by Liébault.

From this time on experiments with hypnotism became general. The common impression that only hysterical patients can be hypnotized will be seen to be false by the statements of Liébault and Bernheim, that on an average from eighty to ninety per cent. of normal persons are susceptible of hypnotism.

More recently, M. J. Luys, in a communication to the Paris Academy of Medicine, declared that when drugs contained in tubes were hung around the necks of hypnotic subjects, phenomena were often developed representing the physiological action which the drug has when taken internally. For instance, morphia, when applied to the left side of the neck, produced in the patient first a sensation of terror, which deepened into one of anger if the application was prolonged. If, however, the morphia was applied to the right side of the neck, the patient sank down into a chair or on the floor, and wore an expression of calm and comfortable repose, such as is induced by a moderate dose of morphia. Again, when brandy, rum or champagne was applied to the neck, the patient passed through all the well known stages of intoxication, with the symptoms of gradual recovery from it.

M. Luys experimented with eighty-six different substances in this way, and found that they could be divided into two groups, in one of which the patient responds automatically, without speech, to the influence of the drug; and in the other, he passes into a condition of somnambulism, in which he is able to hear and to communicate with those about him. Morphia belongs to the first group and alcohol to the second. Valerian is said to produce such a saddening effect

that the patient goes through the different motions necessary to the digging of a grave and the burial of a very dear friend, even to the religious ceremonies before the cross.

These statements are so amazing that one's powers of belief are for the time hopelessly staggered. It will be no doubt wise to await the report of the committee appointed by the French Academy of Medicine to investigate M. Luy's results, before expressing an opinion as to the accuracy of his observations. It should be stated, nevertheless, that M. Delbœuf has been putting to the test one of the oldest claims in regard to hypnotism, namely, that a magnet will produce trembling and tingling, and at times contractures of muscles, and even cause a contracture to be transferred from one limb to the other. He finds that, whether such results follow or not, depends upon the expectation of the patient. If he thinks he has been given a magnet, the sensations described occur, but not otherwise. Further, it is stated in *Science* that Dr. Voisin has confirmed M. Delbœuf's conclusions, and finds, moreover, on investigating M. Luy's results, that when the utmost care has been exercised in talking to his assistants in the presence of the hypnotized subject, so that the latter may have no inkling as to the physiological effect of the drug, the result of hanging drugs about his neck is negative.

As to the therapeutic uses of hypnotism, they will be readily guessed from the fact that a suggestion to a hypnotized patient is promptly accepted, firmly believed and readily acted upon, and from an understanding of the condition of partial anaesthesia which exists during this condition. The latter was the first to be utilized. A French physician attempted to deliver a pregnant woman, without pain, while she was hypnotized. In this he was only partially successful; for when the labor pains became very severe, chloroform had to be employed. More recently, a surgeon has amputated the cervix for carcinoma, while the patient was hypnotized. The operation seems to have been painless, but it must be remembered that the cervix is not a very sensitive part. Several minor operations have been done with the patient under the influence of hypnotism, such as avulsion of a toe-nail; but it is sufficient merely to mention the fact in order to indicate the practical utility of hypnotism.

In regard to the employment of suggestion to hypnotized subjects for therapeutic purposes, some very striking results have been reported at a meeting of the French

¹ Du Sommeil et des états analogues, etc. Paris et Nancy: 1866.

² De la suggestion et de ses applications à la thérapeutique. Paris: 1886.

Society for the Advancement of Science, at Toulouse, in September last. In the *Deutsche Medicinal-Zeitung*, October 13, 1887, from which paper the information is obtained, Dr. Bernheim, of Nancy, is reported as saying that, in a woman of thirty-five, who suffered from hysterical convulsions and had, in addition, metrorrhagia every eleven or thirteen days, he had been successful by hypnotic suggestion in interrupting this metrorrhagia, and in establishing the regular menstrual period, which then became less painful and exhausting than it had been before. Other physicians who were present reported experiences more or less similar to this one. Hysterical contractures have also been removed by hypnotic suggestion.

One of the most thorough papers, which has yet appeared on this subject, is one by Prof. Aug. Forel,¹ of Zürich, from which some of the information contained in the previous part of this article has been gleaned. After reading Bernheim's book, he was induced to visit Nancy, where he was profoundly impressed by what he saw, and returned from this visit such an enthusiastic convert to the new method, that some allowance must be made for his statements. According to him, the chief therapeutic value of hypnotic suggestion resides in the fact that it continues to exert a powerful influence upon the whole organization of the patient, *after* the sleep is over. Dr. Forel has experimented himself, and reports forty-one cases in which he tried hypnotic suggestions upon others. In fourteen of these cases he failed completely, while the remaining twenty-seven patients were influenced. Among the most remarkable cases which he reports, are six of chronic alcoholism, all of which continued sober and industrious after their dismissal from treatment, though, of course, it could not be told with absolute certainty whether they remained total abstainers or not. One of these patients also suffered from jealousy of his wife, which vanished under hypnosis, and from an old traumatic paresis of his right arm, which yielded to the combined influences of hypnotic suggestion and electricity. Another patient, a physician, in addition to his alcoholism, had twice suffered from acute mania, and had been for years an opium eater, because of severe trigeminal neuralgia. After six weeks of treatment, the patient became a changed man in all respects.

The result of this treatment, in the various

¹ *Correspondenz-Blatt f. Schweizer Aerzte*, August 15, 1887.

forms of insanity in which Forel employed it, was for the most part without good effect.

But that this method of treatment may be exercised with due precaution, it is well to record the statement made by Dr. Larroque to the Medico-Psychological Society (*N. Y. Medical Abstract*) that in a hysterical girl whom he had hypnotized to cure of vomiting, there remained a contracture of the foot, which persisted some months in spite of suggestions. Dr. Larroque thinks this was the result of the neuro-muscular hyperexcitability, which, during certain stages of hypnosis, is sufficiently great to react to the slightest touch or breath, and so result in contracture.

In conclusion, it may be safely said, that a method of treatment which will cause hysterical dumbness and various forms of hysterical paralysis and even hystero-epilepsy to disappear, is of great service to the specialist in nervous diseases; care should, however, be exercised in its use, and the utmost exertion of medical men should be employed to keep it from being used by base men or for base purposes.

A CASE OF CEREBRAL RHEUMATISM.¹

BY J. B. CARRELL, M.D.,
HATBORO, PA.

On account of the rarity of cerebral rheumatism, I think it worth while to report the following case: During the afternoon of May 10th, this year, I was called to see Miss W., aged about twenty-five years. I found her in bed, suffering much pain in the back and in the articulations of one arm. The temperature was 102°, and the pulse 80. The case was plainly one of acute articular rheumatism, and I prescribed, as anti-rheumatic remedies, salicylate of soda and colchicum, and, to relieve the pain, positive doses of morphia.

The following morning the patient's temperature was the same (102°), and the pulse 90. The severity of the pain was considerably lessened. The same treatment was continued. By the morning of the 12th, all of the joints of the body had become involved, constituting a typical case of acute poly-arthritis rheumatism. The temperature, strange to say, was now one degree lower, being 101°, and the pulse was 96. The joints were much swollen and very painful,

¹ Read before the Adjunct Montgomery County Medical Society.

the least motion producing agonizing pain. The amount of morphia was increased, so as to give as much comfort as possible and to secure sleep. The brother of the patient being a physician, was now sent for, and arrived the next day. The temperature was 101° , and the pulse 96, the same as the previous day. There having been but slight action of the bowels, we concluded to take the morphine off for a few hours, so that they might be acted upon. The following medicine was given: \mathcal{R} Sodii salicyl., gr. xx; vin. colch. rad., gtt. xv; tincture digital., gtt. x. Mix. This was given every three hours, alternately, with: \mathcal{R} Hydrarg. chlor. mit., gr. ss; pepsin sacch., gr. iij. Mix. In a few hours the bowels were freely acted upon. Then the calomel was discontinued, and the morphia was given again.

The next morning our patient was more comfortable, being able to move herself a very little. The temperature was 100.5° , and the pulse 84. During the night there had been several loose evacuations from the bowels, and profuse sweating was established. All through the day she was comparatively comfortable, and at my evening visit the temperature was 100° , and the pulse 86.

There being much nausea, and the pulse showing a tendency to weakness, I was obliged to discontinue the anti-rheumatics, and gave four grains of quinine and ten drops of tincture of digitalis alternately every two hours, with morphia and tincture of belladonna. On the morning of the 15th every symptom was favorable; the temperature was 100.5° , and the pulse 84. Throughout the entire day nothing unusual occurred. The next morning I found her much worse. For some unaccountable reason there had been a redevelopment of the disease in a more intense form than before. The temperature was 103° , but the pulse was only 84; the skin was hot and dry; the tongue was heavily coated, and there was a tendency to mental wandering. I prescribed: Extract ipecac., fld., gtt. ss; ext. jaborandi fld. gtt. vi; tr. digital., gtt. xij; every four hours, and one-half grain of morphia as needed to control the pain. During the afternoon the patient became quite delirious. On the next morning I found her temperature 101.5° , and the pulse 90 and full. The delirium had now assumed an active form. Ice was applied to the head, and blisters to the temples. Fifteen grains of salicylate of soda was added to the liquid mixture, and large doses of bromide of potash to the morphia. In the afternoon I found the

symptoms worse. It was with difficulty she was kept in bed. I took off the liquid mixture and gave: Potass. bromid., gr. xx; tinct. aconit. rad., gtt. iij; alternately with morphia. As the disease advanced upon the brain it abated upon the articulations. By the morning of the 18th, nearly all of the marks of inflammation had disappeared from the articulations.

Her delirium was the wildest I have ever seen, it being necessary to keep her under constant guard. The temperature was 102° , and the pulse 110. It was almost impossible now to administer remedies. About the middle of the day she went into coma, and at 6 P. M., after a slight convulsion, died.

It is seldom we see cases of rheumatism in which all the articulations are involved, and the cases are infrequent in which the metastasis is as marked as in this one. Twelve hours after the disease had shifted to the brain, all evidence of articular inflammation had disappeared. At first there was a severe onset, then a remission, then a redevelopment of the disease in a severer form than at first, and finally a shifting of the disease from the articulations to the brain, and finally death.

The first attack was mitigated with positive doses of salicylate of soda and colchicum, aided with free action of the bowels.

Fortunately, cases of the kind just described are very rare, and according to statistics are generally fatal. In conversation with my neighboring physicians, they could not call to mind a similar case in this section. One of my competitors, without seeing the case, said he considered it one of measles.

ADHERENT PLACENTA, WITH HOUR-GLASS CONTRACTION, IN THREE CONSECUTIVE PREGNANCIES.

— BY G. B. WOODS, M.D.,
WEST ALEXANDER, PA.

I was called in February 24, 1884, to attend Mrs. C. Bell, in her third accouchement. The child, a well developed female, was born an hour before my arrival. On examination of the mother I found a retained and adherent placenta, with hour-glass contraction of the uterus. I delivered the placenta by the introduction of my right hand, gradually overcoming the contraction of circular fibres of the womb, and detaching the adhered surface of the after-birth. In a short time the patient rallied, and she made a good recovery.

On February 1, 1886, I was again sent for to attend Mrs. B., but, being absent from home, Dr. Wm. Denny attended her. I arrived at the house a short time after the delivery of the placenta, which was adherent, with hour-glass contraction of the uterus.

On October 23, 1887, Mrs. B. was again confined. The child was born an hour before my arrival. I found the patient very much exhausted from hemorrhage, with countenance pale, pulse feeble and fluttering. I proceeded to deliver the placenta as on the first occasion, and accomplished this after some difficulty.

At this date, October 27th, the patient is doing very well.

SOCIETY REPORTS.

PHILADELPHIA NEUROLOGICAL SOCIETY.

Stated Meeting, October 24, 1887.

MORRIS J. LEWIS, M.D., in the chair.

Dr. J. T. ESKRIDGE presented a paper on

Mental and Nervous Diseases as Influenced by the Climate of Colorado.

DR. F. X. DERCUM reported

A Case of Unilateral Convulsions, and Another of Hemiplegia Occurring in Uremia.

The following cases are of interest in connection with the observations of Raymond,¹ and of Chantemesse and Tenneson,² in the same field, and also in connection with two cases of hemichorea, associated with Bright's disease, recently reported by the writer.³ They are as follows:

Case I.—H. S., colored, aged sixty-nine years, an inmate of the Philadelphia Almshouse, had, while in the out wards, occasionally suffered from convulsions. On several occasions he had been admitted into the epileptic ward of the hospital. Here it was noticed that he usually had several convulsions in close succession, each lasting about

five minutes, and that after the attack was over he would fall asleep. His convulsions were always general, and attended with frothing at the mouth.

Mentally he was much impaired. He had delusions of persecution, and sometimes imagined himself unable to walk. He was also at times violent and maniacal during the night, requiring to be strapped in bed.

On August 15, 1887, being much improved, he was, at his own request, again transferred to the out wards.

On August 27, after having had occasional fits for several days, he was again admitted to the epileptic ward. On this day his convulsions seemed much worse than usual. They were almost continuous, and he was brought into the ward in a semi-conscious condition. In striking contrast with the seizures previously observed, the spasms now existed only on the left side, beginning apparently on the left side of the face, extending quickly to the left arm and thence to the left leg, being less severe in the last-mentioned member. During the quiescent periods it was observed that the left arm was paralyzed, as was also to some extent the left leg. The left side of the face was also paralyzed, the mouth was drawn toward the right, and the left cheek was flaccid. The conjunctiva of the right side was sensitive, but that of the left was not. The urine was drawn and examined for albumin, but none detected. The temperature was 97.2°; pulse, 140. The sphincters were relaxed.

After the convulsions had ceased altogether the patient slept. Consciousness had evidently been absent during the attack, but on the following morning, August 28, it had fully returned. The condition of left hemiplegia, however, persisted. His urine was now examined a second time, and revealed both albumin and casts, the latter in large numbers.

On the evening of the 28, the convulsions recurred, the patient having nineteen in rapid succession. On the morning of the 29, he was again conscious, and talked, but during the day he gradually became weaker and died at one o'clock.

An autopsy was held within the following twenty-four hours, and revealed the following: Calvarium of moderate thickness. Dura very adherent, the brain being removed in the calvarium. Pia not thickened, but its meshes very cedematous. Veins of vertex full. Pia presented milky opacities here and there, and was easily separated from the convolutions, a sub-pial space having been formed, which was distended

¹ Raymond "Sur la pathogenie de certains accidents paralitiques observés chez des vieillards, leur rapports probables avec l'urémie," *Révue de Médecine*, Sept. 1885.

² Chantemesse et Tenneson: "De l'hémiplegie et de l'épilepsie partielle urémiques," *Révue de Médecine*, Nov. 1885.

³ F. X. Dercum: "Two Cases of Hemichorea Associated with Bright's Disease," *Journal of Nervous and Mental Diseases*, xiv., August, 1887.

with lymph; vessels of the base of the brain extremely atheromatous. Brain as a whole soft, flattening by its own weight. Ventricles large and excessively pale. Choroid plexuses very pale and cystic. Velum interpositum presented whitish granulations. On section, the cortex was found pale and the white matter excessively oedematous. Serial sections of both hemispheres *failed absolutely* to reveal a focal lesion.

In the general post-mortem nothing of special importance was found except that the kidneys were *markedly granular* and fatty. The lungs were emphysematous, the heart fatty, and the aorta somewhat atheromatous.

Case II.—J. H., eighty-two years old, white, in the out-wards of the Philadelphia Hospital, complained of weakness in the left arm and leg. This continued for four weeks, when he was admitted to the nervous ward of Dr. Mills, temporarily under my care. Here it was noticed that he dragged the left leg a little in walking, and that he moved his left arm with difficulty. Sensation on the affected side was also dulled. The hemiparesis grew gradually more and more pronounced, and was as sharply defined as a hemiplegia of organic origin, which, indeed, it was at first supposed to be. At last, though sluggish mentally, he was able to reply to questions and to make his wants known in his native (German) language. Gradually, however, he failed in mind and body, incontinence of urine, delirium and coma set in, and after having been in the ward two weeks he died. During life the urine had been examined and revealed a small amount of albumin.

On the day following death the autopsy was held, and the following conditions noted: Calvarium and dura normal. The pia arachnoid loose and very oedematous, its meshes milky. Vessels of the base of the brain were very atheromatous. Ventricles excessively pale. Choroid plexuses presented numerous large cysts. The velum interpositum was infiltrated. The brain itself very soft, and on section, found to be oedematous throughout. Careful serial sections *revealed no focal lesion*.

The kidneys were found to be *much contracted and cystic*, markedly cirrhotic.

The other organs revealed nothing of consequence. The lungs presented some adhesions in the right pleura, the heart valves were thickened, the aorta was atheromatous.

Both of the above cases are doubtless to be relegated to affections of the nervous

system occurring during and as a consequence of Bright's disease. Chantemesse and Tenneson¹ have already recorded two instances of unilateral epilepsy occurring in the course of this affection, and have verified one of them by post-mortem examination. Their cases are in everyway a counterpart of the case here reported. The convulsions were strictly limited to one side, and the autopsy revealed merely general oedema of the brain and chronic interstitial nephritis.

The objection may be made that these phenomena of hemiplegia, hemichorea,² and hemi-eclampsia, are due simply to atheroma of the arteries of the brain, by means of which a portion of the cortex or a tract of the internal capsule may receive an imperfect blood supply, be shut off, as it were, from its necessary amount, an oligæmia and oedema being the result. The weight of evidence, however, is against this interpretation. There are absolutely no areas of local softening or local necrosis to be detected, and the oedema is not confined to a spot, but is general, is evenly diffused, and apparently as much in one hemisphere as in the other. Besides, the ingenious experiments of Raymond³ leave no doubt as to the possible one-sided action of the nervous system in uræmia. It will be remembered that he first mutilated the sympathetic system of an animal by removing the superior cervical ganglion of one side. In this way he threw the entire nervous apparatus, so to speak, out of balance. He then ligated the hili of both kidneys, and the convulsions that ensued were limited to one side. He repeated the experiment a second time with the same result. It seems as though the two halves of the nervous system bear unequal powers of resistance and that the weakest yields.

DR. OSLER asked if, at the autopsy, special attention was paid to comparing the two sides of the brain. It was some time since he read the articles to which reference had been made, but his impression was that more oedema had been found on the side of the brain opposite to the side on which the paralysis was present. An interesting point in these cases is that it appears to be absolutely impossible in certain cases to make a satisfactory diagnosis between cases of hemiplegia from apoplexy and cases of hemiplegia from uræmia. He recently went over this question with his class in the case of a man brought into the hospital with hemiplegia,

¹ Loc. cit.

² Dercum, loc. cit.

³ Loc. cit.

unconscious, and with albumin and tubercasts in the urine. He said that it was in all probability a case of hemorrhage, but that it was impossible to exclude positively hemiplegia due to uræmia. He said that it might be a case of œdema of the brain from uræmia, in which the œdema, being more marked on one side of the brain, or from some other cause, the paralysis was unilateral. He had seen one case of unilateral convulsions occurring in a man who was brought into the general hospital at Montreal some eight or nine years ago. He had convulsions for three or four days. At the autopsy in that case nothing was found in the brain that would account for the convulsions. At that time we were not so familiar with œdema of the brain, or with the relation of œdema of the brain in Bright's disease as we are now.

DR. JAMES HENDRIE LLOYD said that Dr. Dercum may recall the fact that, at the meeting of the American Neurological Society two years ago, Dr. Lloyd had referred to a case similar to those just reported. The patient was a boy, aged seventeen years. When he saw him he was in a comatose condition with convulsions, which were confined to the right side of the body. The boy had been a sot, and died a few hours after he saw him. At the autopsy there was nothing found in the brain to account for the condition. The only lesion was the "pig back" kidney. This case was undoubtedly one in which the symptoms resulted from uræmia. He thought that in the intervals between the convulsions it was possible to demonstrate the fact that the side on which the convulsions occurred was paralyzed.

DR. MORRIS J. LEWIS said that a man, aged twenty years, a heavy drinker, under his care, had albumin with granular and oily casts in his urine. He suffered with frequent convulsions, which usually followed the periods of heaviest drinking; and on two occasions the convulsions were most marked on the right side, and were followed by paresis, which lasted two or three days. The young man was placed in a position where he could not obtain alcohol, and has apparently made a complete recovery. There is at present no albumin, no casts, and no paresis.

DR. DERCUM said that, to the best of his recollection, the authors to whom he had referred, have noted no local œdema. He had made three post-mortems in cases of well marked hemi-disease occurring during uræmia, and he had found no more œdema on one side than on the other. The cases

reported by Drs Lloyd and Lewis are of special interest as occurring in young persons. Most of the cases reported have occurred in old people. With reference to local cerebral manifestations from a general cause like uræmia, he recalled the case of a gentleman under his care for several years, who suffers from chronic contracted kidney. He now and then has general uræmic convulsions. Some years ago he had the following remarkable seizure. He went down town to attend to some business, and while in a bank he suddenly became aphasic. He was perfectly conscious. The aphasia continued for several hours. This looks like another instance of a local manifestation from a general cause.

Mental Affections Associated with Chronic Bright's Disease.

DR. WILLIAM OSLER said that as it was in close connection with the paper of Dr. Dercum, he should like to make some reference to the occurrence of certain mental affections which come in connection with chronic Bright's disease. It is well known that certain mental phenomena occur in connection with chronic renal diseases besides simple uræmic coma. He had reported one case of violent mania in a man aged forty-two years, the subject of Bright's disease. When brought to the hospital, he had been maniacal for three or four days. He subsequently became comatose and died. A very interesting case was recently under his care in the University Hospital. A man was brought to the hospital Thursday evening. He saw him on Saturday. He was then quiet, in a semidosing condition, but could be aroused and gave a very intelligent account of himself. The whole clinical picture was that of chronic interstitial nephritis. He thought it not improbable that the man might pass into a condition of coma. There was nothing to attract special attention to his mental condition, and he did not regard his condition as critical. That night he got out of bed in the absence of the attendant, wandered about the ward and finally jumped out of the window. It was subsequently learned that, before admission to the hospital, he had been violent, requiring two or three men to hold him. We were not told this when he was brought to the hospital. He had no doubt that this was an instance of mental disturbance due to chronic nephritis. He was told by one of the physicians who had attended him, that the man was full of delusions. He thought that his wife and others were persecuting him.

He saw another interesting case a year ago last Christmas. This occurred in the practice of Dr. Mullin, of Hamilton, Canada. Here there was also a medico-legal question. It was whether or not the man was in a condition to make a will. There was no doubt as to the existence of chronic Bright's disease. The mental condition was peculiar. He believed that his wife and others had designs upon his life, and it was with difficulty that he could be persuaded to take food. He thought that people were persecuting him. Although he gave a very intelligent account of himself, it was not considered advisable that he should make his will at that time. He was placed upon a somewhat more active treatment than he had previously received. This man subsequently did well, his mind had cleared, and he recovered sufficiently to get about and to make his will.

DR. DERCUM said that the negro, who was the subject of unilateral convulsions, had also presented, at various times, periods of maniacal excitement and had also had delusions of persecution.

PHILADELPHIA CLINICAL SOCIETY.

Stated Meeting, October 28th, 1887.

The Vice-President, DR. MARY E. ALLEN, in the chair.

DR. SOPHIA PRESLEY reported a case of

Rectal Polypus.

Willie C—, a child, six years of age, pale and sallow, who had always been delicate and of a constipated habit, was brought to my office by his mother, who said that he had been suffering from "piles" for about three months; that whenever he had an evacuation from the bowels, there was blood partially covering the stool. This blood caused her to make an examination of the parts, when invariably she found a *fleshy mass* as large as a cherry protruding from the anus. After a short time it would disappear, and not be visible until after the next evacuation.

She had, previously, consulted another physician, who considered the case one of hemorrhoids, and treated it with various ointments, but without any beneficial effect.

I made an examination, but could detect nothing abnormal in appearance, nor by the finger. To help correct the torpidity of the liver, and to overcome the constipation, I ordered:

R Hydrarg. chlor. mitis.....gr. ij
Pulv. ipecac.....gr. ss
Sacch. lact.....gr. xx

M. ft. chart., no. xx.

Sig. One powder to be taken every two hours.

After taking the powders the child was to take a dose of magnesia, and then continue with the following mixture:

R Acid. tartaric.....gr. j
Pepsin (Jensen's).....gr. xxiv
Glycerin,
Liq. menth., pip.....āā f 3jss

M. Sig.—Teaspoonful after each meal.

To be used locally:

R Unguent. belladon.,
Unguent. acid. tannic.....āā 3ss

M. S.—To be used night and morning in and about the anus.

I requested the mother to return with the child at the expiration of a week. At the appointed time he was brought, with the report that he was brighter and better, generally, but the bleeding still continued; and that the lump appeared at each evacuation, as it had done previously.

As she did not live far away, I asked her to send for me when she again noticed the protrusion. I was called the next morning, and, upon examination, found a purple-red polypus, as large as a cherry, protruding from the anus. Upon making a digital examination I found the growth was attached just above the internal sphincter, on the posterior wall of the rectum, by a pedicle about one-sixth of an inch in diameter.

The following morning I removed the polypus by cutting the pedicle, and to make *perfectly sure* there would be no *bleeding*, I injected about two tablespoonfuls of ext. hæmamelis virginic. fld., diluted with one of water, into the rectum, and ordered more of the mixture to be used in the same way should any bleeding be noticed. The child was to be kept perfectly quiet on the lounge, all day.

I left the house, satisfied that I had performed a successful operation, and had rendered hemorrhage impossible. But when I reached home, after making my other calls, I found that a messenger had been there, two hours before, urging my immediate presence. When I reached my patient he was almost in a state of collapse from loss of blood, but from outward and visible signs the bleeding had ceased.

Soon after I left in the morning the child had an inclination to use the commode, and while seated thereon his extreme pallor frightened the nurse, who quickly laid him on the lounge. About half a teaspoonful o

blood was discovered in the vessel. His mother immediately injected the hæmamelis, with apparent good effect. Recognizing the grave aspect of the case, I felt the necessity of keeping up the strength of the patient and preventing a recurrence of the hemorrhage, while, at the same time, warding off septic symptoms. This I endeavored to do by administering quinine, in one grain doses, three times a day, giving as nourishment, milk, milk-punch, wine, beef-tea and broths of various kinds.

About the third day his skin presented a jaundiced appearance, and there was distension of the abdomen, without tenderness.

I now saw the importance of freeing the intestines from the accumulated blood and fecal matter; and for that purpose administered a large dose of castor oil, but without effect. I gave him another dose with the same negative result. I then gave an enema of warm sweet oil, which he retained, and an hour later, one of warm water, after which he had a passage of fetid, coagulated blood. For fully three days, these bloody, offensive evacuations continued at frequent intervals. At the expiration of that time the patient showed signs of decided improvement, although the unhealthy appearance of the skin remained.

The vigorous use of proper stimulants, tonics and nourishment, gradually induced a more healthy condition, and in a reasonable length of time he recovered his original strength; and has since (a period of almost three years) shown no symptoms indicating a recurrence of the trouble.

In conclusion, Dr. Presley said:

"Although the operation was successful, in the end, all the accompanying symptoms convinced me, that to have prevented hemorrhage and its attendant consequences, I should have ligated the pedicle.

DR. EDWARD E. MONTGOMERY then exhibited a set of O'Dwyer's tubes for Intubation, also those modified by Waxham, of Chicago; and gave an analysis of twenty-five cases on which he had performed the operation.

Of these, twenty-two were seen in consultation with other physicians, many when the chances of a successful operation were impossible.

One of the three cases in Dr. Montgomery's own practice, was the victim of a second attack of croup; the child requiring the tube a second time six months after a previous operation.

All of these cases were successful.

Ten of the twenty-five cases had diphtheria, and six of them recovered. The remaining fifteen who were operated upon, were afflicted with membranous croup, and seven recovered.

The most frequent cause of death was broncho-pneumonia.

The youngest child, to recover, was sixteen months old; the oldest, eight years.

Eleven of these children were under three years of age; six recovered. Of the fourteen over three years, who were operated upon, seven recovered, showing a greater percentage of recoveries in favor of those under three years,—a decided advantage intubation has over tracheotomy, which is considered less favorable in persons under three years of age than later.

The shortest time the tube was worn, in a case which recovered, was three days; the longest time was three weeks.

In conclusion, Dr. Montgomery urged the value of this operation, stating as its advantages over tracheotomy:

1. The greater readiness with which parents will give their consent to an operation in which no anæsthetic and blood-letting are necessary, thus gaining valuable time by operating early.

2. The same skilled attention is not necessary, after intubation, as after tracheotomy.

The secretions are apt to become dry and accumulate in the tracheotomy tube, rendering its frequent removal and cleansing imperative.

In intubation the air passing through the mouth keeps the membrane moist, and there is no necessity for the removal of the tube.

—In the *Canada Medical and Surgical Journal*, October, 1887, Dr. Osler says that American physicians are much more pronounced as regards the style of their door-plates and professional cards than English physicians are. He thinks that a large card, say about five inches by three, with gilt and indented edges, and having at the top several specialties and below office hours and telephone number, stamps the man as on the border land, or already in the wastes of quackery. He is charitable enough to believe, however, that some men, particularly young graduates, err in this matter through ignorance, and thinks that medical students should receive, before graduation, a short course of lectures on medical ethics and on the business and legal relations of the doctor. This plan was adopted last year at the University of Pennsylvania.

HOSPITAL NOTES.

LARGE GOITRE.—IMPROVEMENT
UNDER LUGOL'S SOLUTION.

Reported by M. Howard Fussell, M.D., one of the
Physicians to the Medical Dispensary of the
University Hospital.

In September, 1886, the patient, Julia C—, eighteen years old, presented herself at the dispensary, with the following history:

Eight years ago she first noticed a beginning enlargement of the throat, which gradually increased, and was accompanied, until her present visit, with increasing dyspnoea, and failure of strength. There was no family history of goitre, though a younger sister has a very prominent thyroid.

The patient was very anæmic, complained of some palpitation of the heart and dyspnoea, together with difficulty in breathing when lying on her back.

On examination, a huge tumor, which proved to be the enlarged thyroid, filled the *entire interval* between chin and the sternum. On closer examination the tumor was found very tense, pulsating markedly, and there was a distinct thrill and murmur in the left lobe. The isthmus of the thyroid projected as a distinct swelling of the size of an unhulled walnut.

Each carotid was pushed back entirely out of its normal course. In the left carotid a distinct thrill could be felt and *bruit* heard, both due to pressure. The thrill and *bruit* observed in the tumor were doubtless transmitted from the compressed vessels.

The neck measured *nineteen* inches in circumference. An examination of the heart showed that its action was regular, and that there was no hypertrophy. Over the base of the heart was a soft, blowing murmur. There was no prominence of the eye-balls. The patient was put at once on syr. ferri iodidi and liq. iod. co., 30 drops of the former, and 15 drops of the latter, three times a day.

She has reported at the dispensary at intervals of a month, and says that a gradual improvement has occurred. The distressed breathing first became easier, the anæmia gave place to a natural color of the skin, and dyspnoea gradually disappeared. At her last visit, which was made a few days ago, the following note was made:

The neck measures *seventeen* inches; tumor appears much smaller, is soft to the

touch, while no thrill nor murmurs are to be found either in it or in the compressed carotid. The patient appears in excellent general health, and does not suffer from dyspnoea or palpitation of the heart.

The Lugol's solution was continued.

Cascara Sagrada.

In the *Therapeutic Gazette*, for March, 1887, the writer gave his experience with the above drug in fifty carefully observed cases with the following results:

Of the fifty cases the drug was useful in forty-three (43). It entirely failed in seven (7). In the forty-three favorable cases the dose of the drug was diminished in twenty-nine instances after using it for a longer or shorter time. In *no* instance was it found necessary to *increase* that dose which by trial had been found sufficient to cause a daily evacuation of the bowels.

The fluid extract was the preparation used, in 20 drop doses three times a day.

Continued use of the drug, both in private and dispensary practice, tends to strengthen the writer's opinion as to its value as a laxative in chronic constipation, and enables him to recommend it as a valuable addition to our armamentarium.

Medical Dispensary, University Hospital, November, 18, 1887.

A Monument to Audubon.

At the recent meeting in New York of the American Association for the Advancement of Science, the fact that the remains of the great naturalist, Audubon, lie in an obscure and little visited portion of Trinity Cemetery, New York City, and that his tomb is unmarked by any distinguishing monument, was brought to the attention of the members. At the first autumn meeting of the New York Academy of Sciences, a committee was appointed to solicit funds and make all arrangements for a monument. This committee has organized, with Dr. Britton as secretary and treasurer, and is now ready to receive subscriptions. Checks should be made payable to N. L. Britton, treasurer, and post-office orders should be drawn on Station H, New York city. The committee estimates that between six and ten thousand dollars will be required to erect and engrave a shaft worthy the memory of America's first naturalist, and, while confident that this amount will be forthcoming, desires to have interest taken in the project by scientists in all departments, in all portions of the country.—*Science*, Oct. 28, 1887.

EDITORIAL DEPARTMENT.

PERISCOPE.

A Marvellous Voice.

Most people who have been to the "Wild West" show at Earl's Court must have been struck by the enormous vocal power displayed by Mr. Frank Richmond, the "Orator," who explains the action of the realistic drama so vividly presented by Buffalo Bill's cowboys and redskins. The voice of this modern Stentor is a physiological curiosity in its way, for he has often made himself distinctly heard by an audience of thirty thousand persons in the open air. This throws Mr. Gladstone's famous record at Blackheath in 1874 altogether into the shade. Some idea of the vast amount of work which the "Orator" gets out of his vocal organs may be formed from the fact that his running commentary on the show contains more words than the part of Hamlet, which, as is well known, taxes the powers of the best trained actors. This severe effort the "Orator" makes—and makes successfully—twice a day for months together, under much less favorable acoustic conditions than players even in the largest theatres. A few physical details respecting such a vocal athlete may, therefore, be interesting to some of our readers. For these we are indebted to the courtesy of Dr. Robert C. Myles, of New York, whose examination, it may be added, was confirmed by Sir Morrell Mackenzie. The vocal cords are of ordinary length, and not much above the average in breadth, but the vocal processes at once strike the observer by their extraordinary development. They project inwards towards the middle line like two large spurs when the glottis is open. The great leverage thus given to the laryngeal muscles allows them to act to the best advantage with a minimum of effort. The larynx itself is of a large size, and the pharynx is exceptionally roomy and well developed, whilst the mucous membrane covering it is remarkably free from granulations and roughness of any kind. The "Orator's" vital capacity is not above the ordinary standard, but what breath-power he has he utilizes to the utmost with the art of a trained elocutionist. Mr. Richmond, we believe, was on the stage before he occupied his present position, and the secret of his remarkable delivery lies more in the perfection with which he has learned to use his natural advantages than in any

notable peculiarity of physical conformation. —*Brit. Med. Journ.*, October 1, 1887.

The Epidemic of Military Sweat Rash in France.

On March 16th, of this year, according to the *Lancet*, October 1, 1887, during an epidemic of measles, there appeared a case of *suette miliare* in a young man eighteen years old, living at Sillards, in the canton of Lussac-les-Châteaux. From this first case the disease spread and became epidemic. It was usually preceded by such premonitory symptoms as feverishness, weakness of the legs and general malaise, followed the next night by copious sweating. The nervous symptoms were continued feeling of suffocation, sometimes increased into paroxysms; a sense of epigastric constriction, palpitations, agitation, and delirium. Cramps and contracture of muscles were also observed. The tongue was furred and the bowels constipated. In the first stage cough is habitual, and epistaxis generally abundant. The second period commences with the appearance of the eruption, which consists of two chief features: first, a miliary papule, transformed later into a vesicle, which finally discharges; and, second, a polymorphous erythema, which may be arranged under three forms—a red rash, a measles-like eruption, and a purpura. The measles-like rash appears first, and is followed by the scarlatinal and purpuric forms. The eruption first appears on the face, from which it spreads to the neck, trunk, upper limbs, and finally to the legs. The soft palate is speckled with red; and papules are particularly apt to occur on the forearm and dorsal surface of the hands. *Suette blanche* is composed of papules which remain hard and opaque. Frequently the eruption comes out in successive crops which do not exceed two or three in number. The eruption disappears completely and rapidly, but occasionally the purpuric spots remain a long time. During the eruptive period the fever is less intense, and the stomach derangements and malaise are less pronounced. Constipation, however, continues, and the stools have an offensive odor. The urine is scanty and sometimes suppressed. Copious vomiting of blood has been noted. The eruption is followed by desquamation of the skin, which occurs locally and in large flakes, especially about the fingers and palms of the hands, and which rapidly succeeds the appearance of the eruption. Convalescence is

tedious. The disease affects children chiefly. It is contagious, but there is no evidence of its propagation by water or other ingesta. The period of incubation is said never to exceed twenty-four hours. The mortality of those attacked ranged from twelve to thirty-three per cent. M. Brouardel, who investigated this epidemic at the instance of the French Academy of Medicine, by establishing a cordon around the affected areas, and by disinfecting the clothing, succeeded in checking the progress of the epidemic, which has now practically subsided.

A Mammary Gland in a Dermoid Cyst of the Ovary.

Dr. Desiderius von Velits reports from Tauffer's Clinic in Budapest to *Virchow's Archiv*, a case occurring in a woman forty years old, who had borne twelve children, and in whose ovary on the right side was found a dermoid cyst. In the cyst, besides a mass containing blonde hair, was a mammary gland, corresponding completely in its development to the mamma of a young woman. This occupied the inner surface of the cyst-wall, the latter being 3 mm thick. It was of the size of a child's fist, and from its swollen nipple there exuded on pressure two or three drops of a milky fluid. The areola of the nipple was pale red, and was surrounded by a circle of blonde hair, which was about an inch long.

Histologically, the nipple was rich in nerve and muscle, and the skin, both of nipple and areola, normal. In the nipple was found a very wide sinus, which, as well as the other ducts of the glands, was covered with stratified pavement epithelium. The body of the gland proper was only rudimental; the normal structure of a rudimentary gland was found more in the deeper parts of the gland.

The author regards this as a case of malformation by excess, and thinks that the case is one of polymastia of the ovaries.—*Deutsche Medizinal-Zeitung*, September 29, 1887.

Detection of Metallic Bodies with the Magnet.

In the *Münchener med. Wochenschrift*, 1887, No. 15, Graser describes the case of a man from whose arm four pieces of a needle had been previously removed, and in which the presence of another piece was suspected. By the use of a strong electro-magnet the location of this piece was discovered, and it was afterward successfully removed through an incision at the spot indicated by the magnet.—*Centralblatt für Chirurgie*, Oct. 8, 1887.

Hemorrhage from the Stomach in Typhoid Fever.

In the *Weiner med. Presse*, No. 13, 1887, M. Weiss reports that a student, twenty-two years old, who, two years before had overcome a moderately severe attack of typhoid fever, was taken sick again with typhoid, which presented pretty violent symptoms. There were severe colicky pains, accompanied by bloody stools and moderately high fever. In the course of the second week, there occurred frequent vomiting and increased sensibility in the epigastric region. After a sudden rise of fever from 100.5°, at six o'clock in the evening, to 105.4° at eight o'clock, there occurred at ten o'clock the vomiting of about $\frac{1}{2}$ liter of a chocolate-colored, acid mass, intermingled with brownish crumbs. Soon afterwards the patient again vomited, this time about $\frac{1}{2}$ liter of black blood; and as a result of frequently repeated hæmatemeses, the patient died on the following morning.

An autopsy was not made, but the author is of opinion that the vomiting of blood was not the result of an accidental complication, but depended upon a typhoid change in the mucous membrane of the stomach. He bases his opinion upon the following argument: A perforating ulcer, or a new formation in the stomach in a condition of ulceration, is, apart from cirrhosis, very properly excluded in a healthy young man who had never had symptoms referable to the stomach, and was not intemperate or syphilitic. Moreover, the so-called hemorrhagic diathesis, which is sometimes present in infectious diseases of a malignant character, did not exist in this case. Finally, the blood could not have come from a section of the colon, which had become glued to the intestine, because the odor of the vomiting was not fæcal.—*Centralblatt f. d. med. Wissensch.*, October 8, 1887.

Treatment of Acne.

Lassar recommends, in the *Therapeutische Monatshefte*, 1887, No. 1, the application of Wilson's ointment, prepared as follows:

B	B-naphthol.....	10 parts.
	Sulphur præcipitat.....	50 "
	Vaseline (or lanolin),	
	Saponis virid.....	āā 25 "
M.	—Rub gently together to make a paste.	

This ointment is to be smeared on in a layer as thick as the back of a table-knife, and carefully removed, after thirty minutes, with a soft rag. After this the part is to be powdered with talc.—*Centralblatt für Chirurgie*, Oct. 1, 1887.

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REMOVING THE OVARIES OF INSANE WOMEN.

A very interesting and suggestive paper on the relation of disorders of the sexual apparatus, or perverted sexual feelings, to mental disturbances in women, appears in *St. Bartholomew's Hospital Reports*, Vol. xxii, from the pen of Dr. T. CLAYE SHAW, of the Middlesex County Lunatic Asylum. In this paper the author propounds more questions than he answers; but the general tendency of his views seems to be that morbid conditions of the sexual apparatus, and morbid sexual manifestations in the insane are to be considered as concomitant with or dependent upon the disorder of the brain, rather than as caused by the physical state of the procreative organs. He appreciates the advantage, in many cases, of investigation of the sexual apparatus in women with

perverted sexual feelings, and the beneficial results which have been obtained in American hospitals for the insane by operative interference in such cases. But, on the whole, Dr. Shaw thinks that the risks of such methods more than counterbalance their advantages to the patient, and his practice and advice is to treat the mental disorder as the cause of the troubles which appear in its course.

From the statement of his experience, we incline to the belief that he might be a little bolder without damage to his main argument. For example, he cites the case of a young married woman who has attacks of mania, coincident with her monthly periods and accompanied by most lascivious demonstrations; while in the intervals between her periods her conduct is perfectly correct. If these attacks continue, he says, dementia must necessarily ensue. And yet, he asks, in regard to this woman: "Would it be right to remove her ovaries?" To this question he gives no positive answer; but we would say, "Undoubtedly, provided the consent of those who are her natural guardians could be obtained." Suppose the operation did not abolish this woman's insane attacks. She would be no worse off without her ovaries, and the frightful risk that she may conceive during one of her free intervals and give birth to a tainted offspring would be averted. Suppose she were to die as a result of the operation. Who would not consider the fact that she happened to be one of the very few who make up the small percentage of deaths, a very questionable misfortune? On the other hand, suppose that she were to be cured of her periodical insanity. What would the loss of her power to procreate be to the gain of sanity! In any of the events supposed, we believe the operation would be justifiable.

More than this, while we have a proper aversion to the idea of mutilation in the abstract, we believe that, in deciding upon the propriety of removing the ovaries of insane women—especially insane married women—the advantage of abolishing the power of procreation deserves careful con-

sideration. Let him, who questions this, watch the progress of insanity in a married woman; see her become pregnant; attend her in her confinement; assume the responsibilities and anxieties of caring for her and her blighted offspring afterwards; and reflect upon the curse which these events impose upon all concerned. All this is within the experience of the writer of this Editorial, and has some influence in shaping his opinion, that the certainty of preventing procreation in insane women, by removing their ovaries, should be regarded as one of the greatest merits of the operation; and that the risk to their lives is an insignificant offset to the possibility that their reason may be restored.

We would not be misunderstood in this matter, or seem to justify recklessness in removing the ovaries in cases of insanity. In what we say we take for granted the exercise of such discretion as a conscientious and competent medical man should use. But we are as thoroughly opposed to the outcry against ovariectomy—made by men, and not supported by women, be it remembered—simply because it is a mutilation, as we are to the temerity of those who would remove the ovaries without due deliberation or for insufficient reasons.

It may be that the zeal of operation has carried some surgeons too far—if so, let their consciences judge them; but there is some risk that purely sentimental objections may hold back good men and skilful practitioners from operative undertakings which would be of the greatest benefit to women themselves and to the human race.

THE BOVINE ORIGIN OF SCARLET FEVER.

In the REPORTER, Aug. 13, 1887, p. 221, we called attention to the fact that Klein had recently made some investigations which seemed to indicate that scarlet fever is communicable through the medium of infected milk. Since then numerous observations in Europe have seemed to warrant the opinion that this disease may have been propagated

from cattle affected with an analogous disease, characterized by the appearance of a pustular eruption upon the teats or udders of cows from which the milk supply was obtained. This matter has attracted more attention on the other side of the Atlantic Ocean than it has in this country; and not a few observers have come to believe that scarlet fever is generally, if not always, propagated from a bovine source.

It would be interesting to have the experience of practitioners in the United States in regard to this matter, especially in the country, where the facilities for investigating the truth of this theory are much greater than they are in the cities; and we call the attention of the readers of the REPORTER to it, because we feel sure that they can make very useful contributions toward deciding whether the cases now being reported with some frequency in England and France are to be considered merely as coincidences, or not.

In a country practice, it ought not to be difficult to ascertain if the cows from which the milk supply of a family is obtained are healthy or are affected with an eruption upon their udders; and a series of cases in which scarlet fever in human beings, and such a disease in the cattle, were found associated would go far toward establishing the theory that scarlet fever is of bovine origin. At the same time, it would indicate a way to diminish the ravages of scarlet fever, the value of which can hardly be estimated.

On the other hand, a series of cases in which no connection could be assumed between scarlet fever and a disease of cattle would set at rest the hypothesis that scarlet fever is usually of bovine origin, and prevent the useless pursuit of an *ignis fatuus* in practice.

In either case a most useful purpose would be served by a well-conducted investigation; and therefore we strongly recommend our readers to avail themselves of the opportunity which many of them enjoy to an unusual degree, to contribute to the settlement of this interesting, but still unsettled question.

THE SEYBERT COMMISSION ON SPIRITUALISM.

We publish in another part of the *REPORTER* some criticisms of Professor Henry Kiddle, under the auspices of the American Spiritualistic Alliance, upon the report of the Seybert Commission of the University of Pennsylvania. Some of these criticisms we regard as well founded; as, for example, that the commission has not yet accomplished what seems to have been contemplated by Mr. Seybert when he made his legacy. On the other hand, we think that its critic has found fault with some of the details of its work which are of a nature unavoidable in any such investigation, and with others which were unavoidable in this particular one. Among the first of these unavoidable details was the selection of some persons outside of the body originally named to conduct the investigation, who by this fact were incorporated into the latter body, which then became responsible for what they did. Another unavoidable detail was the absence of part of the commission from some of the meetings; and no one who is acquainted with the member who attended most of the meetings will suppose that his deafness, to which Prof. Kiddle so pointedly calls attention, by any means prevented him from being an investigator very suitable either to appreciate anything worthy of credence or to discover anything tainted with deception.

The charge of Prof. Kiddle that the commission did not conduct the investigations which they made in a sufficiently serious spirit is, we believe, partly unfounded; and wherein it is true the attitude of the commission was due, not to any unfairness on their part, but to the character of the subject presented to them. We are by no means sure that spiritualism presents no manifestations worthy of serious consideration, or that careful and conscientious study may not lead to the discovery of important relations between disembodied ghosts and mortal men; but, at the risk of being set down as prejudiced, we do not hesitate to say that the manifestations of which we have any knowledge are so contemptible that it seems a waste

of time for men who have any useful occupation to turn aside to consider them.

In conclusion, it is right to say that the Seybert Commission does not regard its work as ended; and that when any spiritualist has evidence to present which is worthy of consideration by men of reasonable and well-balanced minds, it will secure a patient and fair examination by this commission. So far as it has gone, we believe the commission has acted wisely and judged justly. The opinions it has announced are, we believe, those of most scientific men. What it, and all men, shall think in the future depends wholly upon what spiritualists can demonstrate; and until the latter can produce demonstrations very different from those which have been presented hitherto, it will avail little to cry out against the verdict of the great mass of thinking men.

THE TREATMENT OF PNEUMONIA.

A fair experience in the treatment of pneumonia leads us to the opinion that most cases may be conducted to a favorable issue by a method something like the following: If the patient is a strong adult, with a hard, full pulse, venesection from the arm may be very advantageous at the onset of the disease. If the patient is old, or weak, or if the disease has already lasted several days, venesection may be dangerous. When venesection is out of place, supporting remedies must be used. An excellent prescription is composed of five minims of tincture of digitalis, five minims of deodorized tincture of opium, and five minims of aromatic sulphuric acid, with enough tincture of cardamon or lavender to make the whole up to a teaspoonful. This dose may be given every three hours until the frequency and violence of the cough are abated, or until some drowsiness is produced. For persons in adult life, no other stimulant is necessary, as a rule. For old people, the administration of small and frequent doses of whiskey—a teaspoonful every hour—is often of the greatest service.

The local application of large mush poultices, or enveloping the chest in cotton, or fine carded wool, is often comforting and

serviceable. Cupping we have little faith in, although many practitioners, who have used it often, think it of service. In the case of old, weak, or debilitated subjects, we believe it to be dangerous.

If a pneumonia reaches the stage of cyanosis, we would recommend the use of strychnia hypodermically, in doses of $\frac{1}{80}$ to $\frac{1}{30}$ grs., as suggested by Dr. Habershon; although we have had no experience in its use.

It may be scarcely necessary to say that in cases of pneumonia—as of all diseases—it is of the greatest importance to keep the bowels, the kidneys and the skin in good working order. The administration of a prompt, but not violent, cathartic, or of a stimulating enema is often of the greatest service at the outset of a pneumonia. In the later stages a cathartic is rarely demanded. The kidneys may be kept active by the free administration of water, and especially of water combined with nitre. A very good way to accomplish this is to order a teaspoonful of sweet spirits of nitre, to be placed in a tumblerful of water, to which a little lemon-juice may be added, and a tablespoonful of the mixture to be given every hour. This combination has the advantage of acting upon the skin, as well as upon the kidneys, and tends to keep up cutaneous transpiration.

These suggestions cover the main indications in the medicinal treatment of pneumonia, namely, relieving the lungs as much as possible of the work of elimination, lessening pain and irritation, quieting cough, strengthening the heart, and promoting removal of the products of inflammation. For the support of bodily nutrition, attention to feeding is important. Usually not much food is needed, and too much is injurious. The best diet we believe to be one of milk exclusively, given hot or cold as the patient wishes, remembering that when the vitality is low hot milk is to be preferred, and that the digestion of milk is facilitated by adding a little salt to it, ten or twenty grains to a tumblerful.

The method proposed above is not offered as an exclusive one. Different medical men often reach the same goal by different ways.

But this method has given very satisfactory results in the treatment of pneumonia in a large number of cases, many of which were in the persons of aged people, in whom this disease is usually most serious and most apt to be fatal.

SUTURE OF THE URETHRA AFTER LACERATION.

The tendency of modern surgical methods is to attempt to secure immediate union of most wounds by approximation and suture. In many cases such attempts are perfectly rational, and usually crowned with success. In the case of lacerated wounds of the urethra, however, it is by no means clear that immediate closure of the wound gives the best results. The structure of the wall of the urethra, its anatomical relations, and its functions, are such that primary union is hard to secure and not always desirable. At a meeting of the Société de Chirurgie, of Paris, Oct. 26, 1887, M. LUCAS CHAMPONNIERE reported two observations of LOCQUIN, which confirm the statements just made. In one of these cases the attempt to secure immediate union was wholly unsuccessful, and it was necessary afterward to freshen the edges of the opening and reunite the divided canal. In the other, the primary suture accomplished its object; but this was followed some years later by a cicatricial stricture which had to be excised, and a new operation was required to join the separated parts of the urethra.

Justice to the operation of immediate suture requires the admission that the failure may have been due, in these cases, to the way in which, and the circumstances under which, it was performed. If the tissues were much contused, or if the steps of the operation were not carried out with sufficient judgment and skill, the blame of failure cannot attach to the method itself.

The determination what to do in cases of rupture or laceration of the urethra will usually rest upon the conditions which each case presents, and upon the familiarity of the surgeon with the technique of operations upon this part. For uncontused lacerations,

we believe immediate suture should be attempted by any surgeon of fair skill and dexterity; for laceration, with much crushing of the tissues, we think no such attempt should be made. And, if, after a judicious attempt to close a lacerated urethra, union does not take place, we would by no means consider this a contra-indication to the method; nor would we think it just to blame an operation of this kind for a subsequent cicatricial contraction, which might have been much worse if the healing of the laceration had been left to nature.

A CASE OF SO-CALLED HYDROPHOBIA.

In another place, we publish an account of a death from so-called hydrophobia, which occurred recently in New York. It is impossible, of course, to speak with positiveness about a medical matter, on evidence presented by most daily newspapers. But certain points in this case will fix the attention of those who have made a careful study of what is called hydrophobia. First, as usual, there is no evidence that the dog which did the biting was affected with rabies—except the fact of biting several persons, which is not a strange thing for an excited dog to do. Second, there is no evidence that either of the two persons bitten at the same time with the man who died have suffered in consequence. Third, the patient was a drinking man; and intemperance often produces symptoms like those of so-called hydrophobia. Fourth, the account of the case shows that the patient believed he had hydrophobia, and leads to the suspicion that his physicians may have strengthened his belief by what they did or said. Fifth, physical restraint was used and opiates were administered; both of which have a prejudicial effect upon persons in the condition of this unfortunate man.

Taking these facts into consideration, we hope that this case will be made the subject of careful study by those who are familiar with its whole history and all its details; and, until we have further evidence with regard to it, we are disposed to class it with other

cases of pseudo-hydrophobia, caused by the use of alcohol, and shaped by the fear of the patient and the conduct of those about him.

INTERNATIONAL COPYRIGHT.

We publish in another part of the *REPORTER* a statement from the New York *Tribune*, which announces the conclusion of a convention on copyright between Great Britain, Germany, Spain, Switzerland, Tunis and Siberia, which will insure to authors in these countries the rights which they ought to enjoy in all lands. The London *Globe* regrets that the United States is not joined in this convention—and so do we. It is true that American authors probably suffer as much from English piracy as English authors suffer from American. But this fact does not justify the wrong on either side of the water; and we shall use the influence of this journal to dissuade publishing houses in the United States from doing to foreign authors what we consider unjust when done to those of our own country. For we believe that a firm attitude on this subject, by the leading periodicals in England and America, will hasten the day when literary work shall enjoy full legal protection throughout the civilized world.

GLEDITSCHIA.

We publish this week a very complete report, by Dr. Willard H. Morse, upon the vexed subject of gleditschia and gleditschine. This will give our readers an idea of the exact standing of the claims made for this so-called alkaloid. Those who still believe in it have made an attempt to have their process investigated by the Editors of two medical journals in New York, Drs. Shradley and Foster; but as one of the conditions was that the process should not be disclosed, we understand that one of these gentlemen has declined to act as an examiner. The report of Dr. Morse will furnish our readers with information in regard to what gleditschia is and what are its properties, so far as they are now known.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the *REPORTER*.]

LECTURES ON THE DIAGNOSIS OF DISEASES OF THE BRAIN. By W. K. GOWERS, M.D., F.R.S., Professor of Clinical Medicine in University College (London), etc. Second edition. 8vo, pp. vii, 254. Philadelphia: P. Blakiston, Son & Co., 1887. Price, \$2.00.

The first edition of this work was received with great favor by the medical profession, and at once it took its place as one of those which no student of brain-disorders could do without. The second edition contains a correction of certain trifling inaccuracies in the first, and numerous additions suggested by the result of investigations made since its predecessor appeared. The whole is an admirable presentation of the subject of diseases of the brain, chiefly from the standpoint of the physician. It would be hardly fair to criticise the omission of certain features of surgical injuries of the brain; and yet we would be glad if the author would direct his attention to the phenomena resulting from accidental or experimental traumatism of the brain, which have been so thoroughly studied by certain German investigators. It would be especially valuable to have his judgment in regard to the effects produced by injuries to the vaso-motor, respiratory, and heat centres, which are of so much importance in determining the diagnosis and the prognosis after blows upon the skull. We would also be glad to have his views upon the effect of increased tension within the sheath of the optic nerve.

Even without these, however, this book is one of the greatest value, and we can most heartily recommend it to our readers.

ANATOMICAL TECHNOLOGY AS APPLIED TO THE DOMESTIC CAT, AN INTRODUCTION TO HUMAN, VETERINARY, AND COMPARATIVE ANATOMY, ETC. By BURT G. WILDER, B.S., M.D., Professor of Physiology, Comparative Anatomy and Zoology in Cornell University, etc., and SIMON H. GAGE, B.S., Assistant Professor of Physiology, in Cornell University, etc. Second edition, revised. 8vo, pp. xxvi, 577. New York and Chicago: A. S. Barnes & Co. Price, \$4.50.

This rather long title corresponds with those of many German books and papers, in which an attempt is made to indicate on the first page the scope of the work which follows—a practice which may suit authors, but which is a cause of much distress to reviewers. The book before us is an exceedingly thorough treatise on the method of studying anatomy as applied to the domestic cat. Everything pertaining to this subject is discussed in the most complete manner, from apparently trivial details of conduct in the dissecting room to the reasons for adopting a certain terminology. If the book has a fault, we should say it was in being too complete. The introduction, for example, contains an interesting, but hardly necessary, attempt to justify the methods of teaching which the authors have found successful, and the terms which they have adopted after an experience which—if not peculiar—would be repeated wherever their plan secured a fair trial. As a whole, the book is a monument to the patience and industry of the

authors, and a valuable guide to those for whom it is intended.

TRANSACTIONS OF THE ASSOCIATION OF AMERICAN PHYSICIANS. SECOND SESSION, 1887. 8vo, pp. xx, 254. Philadelphia: Printed for the Association, 1887.

The volume before us contains seventeen interesting and valuable papers on a variety of medical subjects. Among the most interesting are that of Dr. Billings on the "Methods of Research in Medical Literature," that of Dr. Bruen on "Bergeon's Method of Treating Phthisis," and that of Drs. Pepper and Griffiths on the "Treatment of Phthisis by Gaseous Enemata." The first of these papers is written in that attractive style which has made Dr. Billings so agreeable, as well as so instructive an authority on the subject he presented. The other two papers are of great value in themselves, and led to the expression of valuable opinions in the discussion which followed them. The status of Bergeon's method at the present time is clearly indicated in the views expressed by the members of the Association of American Physicians, although some of the hopes which seemed justified when they last met have not been realized.

Much of the contents of this volume of transactions has already appeared in the columns of the medical journals—fortunately for the profession; but we can recommend the whole to our readers as a valuable addition to their libraries.

RECTAL AND ANAL SURGERY. By EDMUND ANDREWS, M.D., L.L.D., Professor of Clinical Surgery in the Chicago Medical College, etc.; and E. WYLLYS ANDREWS, A.M., M.D., Adjunct Professor of Surgery in the Chicago Medical College, etc. Illustrated. Large 8vo, pp. x, 111. Chicago: W. T. Keener, 1887.

This admirable book contains not only a succinct and excellent account of most of the diseases, injuries and malformations of the anus and rectum, and a thoroughly reliable description of the most approved methods of treating them, but also a very interesting summary of the teachings and practices of the "itinerant," or "quack," specialists in these troubles who have so recently and so generally flourished in the West. It is true that the Eastern part of our country has not been, and is not now, free from these persons; but the principal field of their industry has been West of the Alleghany Mountains. The authors, with great discrimination, indicate the reasons for their temporary success and the causes of their eventual failure. This feature of the book before us make it almost, if not quite, unique in medical literature, and add much to the value of what, even without it, would be a very valuable book.

A STUDY OF THE HISTOLOGICAL CHARACTERS OF THE PERIOSTEUM AND PERIDENTAL MEMBRANE. By G. V. BLACK, M.D., D.D.S., Professor of Pathology in the Chicago College of Dental Surgery. Large 8vo, pp. ix, 138, with fifteen full page plates. Chicago: W. T. Keener, 1887.

One is apt to run out of adjectives when a series of good or bad books come up for review at one time; so when we wish to express an opinion of the book before us, it is not easy to select those which will be appropriate, without repeating what it has been our pleasant duty to say just before. Dr. Black's essay is a most complete one, and might be taken for an

example of what careful, thorough and ingenious work will produce. We can recommend it heartily to students of dentistry, and of histology, as a mine of information. The plates which illustrate it include 67 original drawings, which reflect equal credit upon the author and upon the publisher. The work of the latter is so good that we pay the book a high compliment when we say that it is as handsome as it is valuable in a scientific sense.

LITERARY NOTES AND QUERIES.

[In this column the REPORTER will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—Mr. Labouchere, Editor of the *London Truth*, says: Mr. Pearsall Smith's suggestion for a copyright treaty with the United States is a most sensible one. Heretofore we have negotiated not so much for our authors as for our publishers. Mr. Smith proposes that we should ask the United States to assent to English authors being allowed a royalty on their works when published in America, with the same reciprocal advantage to American authors here. If this were agreed to, there would be no monopoly. Fifty American publishers might issue a work, and compete with each other in cheap editions, but the English author would get 10 per cent. upon the retail price of every copy sold. This would be payment by results, in its most reasonable form.

—A Convention on Copyright has been signed by the representatives of Great Britain, Germany, Spain, Switzerland, Tunis and Siberia, and will come into force on the 5th of December. It places an author, composer or artist belonging to any one of the countries named in a position of equality, as regards the copyright of his works, with the authors, composers and artists of any of the other countries named. As regards translations, the copyright is to extend over ten years from the completion of the original publication; while in the case of anonymous or pseudonymous works the publisher will be entitled to protect rights belonging to the author. The rule as to books will apply also to periodicals and newspapers for which copyright is claimed; but in the latter instance protection is not accorded to news or to "articles of political discussion."

—The *London Globe* says that "one nationality in particular is conspicuous by its absence from the Convention on Copyright, namely, the United States of America; and until this country is included the Convention can be regarded only as a partial blessing."

—*Littell's Living Age* maintains its usual high standard of selections from foreign periodicals. Just now it is publishing a serial story, entitled "Major Lawrence, F. L. S.," which contains incidentally an interesting description of a patient with phthisis. A short article from the *St. James Gazette*, by Sir Thomas Crawford, maintains that the physical condition of the lower classes in England is deteriorating.

—The Emperor of Brazil is said to be suffering from an advanced stage of diabetes.

CORRESPONDENCE.

Diphtheria.

EDS. MED. AND SURG. REPORTER:

Sirs:—1. Is there a pathological condition that you can in truth call *diphtheritic croup*? Please answer through the REPORTER. I should like to see an editorial on diphtheria and its treatment.

2. Will you tell me the best *treatise* on diphtheria?—at least in your opinion.

3. Have Dr. Formad and his collaborer a work out, on the result of their investigations on diphtheria?

4. If so, can the work be gotten through the office of the REPORTER? Also state price. The REPORTER is fine. I have been a subscriber for many years. Could not well get along without it. Pardon me for troubling you. Yours truly,

H. E. ZIMMERMAN.

Mt. Jackson; Pa., Nov. 12, 1887.

[As a rule, we cut out of the letters we receive all expressions like "your valuable journal," etc.; but the compliment in the end of this letter seems so hearty that we cannot resist the temptation to let it pass.

To the writer's questions, we reply:

1. No. We regard croup and diphtheria as totally different diseases.

2. We cannot name the best book on diphtheria; but we can strongly recommend our correspondent to get "A Treatise on Diphtheria," by Dr. Abraham Jacobi, of New York.

3. The result of the investigations of Drs. H. C. Wood and H. F. Formad have been published as "Appendix A., Report of the National Board of Health for 1887." We advise our correspondent to apply to a Congressman from his district for it.—EDS. REPORTER.]

Prescription for Lumbago.

EDS. MED. AND SURG. REPORTER:

Sirs:—I see a prescription for lumbago in your REPORTER for May 21, 1887, page 667; also repeated October 22, 1887, page 554.

I have been placed in rather an embarrassing position, as our druggist tells me that the prescription cannot be filled without its precipitating. Very respectfully,

G. G. MORRIS, M.D.

708, 13th St., N. W., Washington, D. C.

[On investigating the prescription referred to—with the help of a competent pharmacist of this city—we find that Burggraeve's formula cannot be prepared without precipitation, owing to the action of the water of

ammonia upon the collodion. But an elegant and perfectly clear preparation results if spirits of ammonia be substituted for the water of ammonia, as follows:

R Tr. iodi,
Collodii,
Spiritus ammoniæ.....ââ equal parts.

M. Sig.—Apply with camel's-hair brush.

A clear solution of the same strength results from the combination:

R Aquæ ammoniæ, FFF.....f3j
Alcohol.....f3ij

Mix and add

Tr. iodi,
Collodii.....ââ f3iij

This prescription when first prepared is of a dark wine color; after standing 24 hours, it becomes of a pale amber color, owing to decolorization of the tr. iodi.—EDS. REPORTER.]

A Case of Stricture of the Cardiac Orifice of the Stomach:

EDS. MED. AND SURG. REPORTER:

Sirs:—Having been present at the post-mortem of the late Charles Miller, Dr. Traill Green requested me to write a statement of the case, and send it to you, in answer to your letter to him. I therefore enclose you the history of the case as given me by the widow of the deceased, and an account of the autopsy. The latter was limited to the stomach and vicinity. Mr. Miller was treated by a number of physicians, among whom were Drs. Agnew and Pancoast, of your city.

Case.—Charles Miller, German, aged 51 years, boss carpenter by occupation, had been a sufferer from dyspepsia for about twenty-five years. He was always a very fast eater, wanted his food very hot, and also ate between meals. About eleven years ago he went on a visit to his native country, and returned very much improved in health. From that time on, until the beginning of the spring of 1887, he was able to attend to his occupation. About the 1st of February, 1887, he noticed some difficulty in deglutition. At times the food would enter the stomach, then again it would fill up the œsophagus and be rejected. This condition gradually grew worse, until six weeks before his death (November 1, 1887), when he became unable to swallow any solid food, and could swallow only a small quantity of liquid. His craving for food became ravenous until ten days before he died, when all desire to eat ceased. Rectal alimentation had been resorted to; but to this the patient objected, and it was therefore discontinued.

For ten days before death no nourishment whatever was taken. Thirst became intense, and the patient constantly held ice in his mouth, and let the water run out. He always expressed himself as feeling well, except a choking and burning sensation at the epigastrium.

The autopsy revealed a thick and indurated constriction around the cardiac orifice of the stomach, connected with a large tumor on its left side. The tumor was one inch thick and two inches in diameter. Upon microscopical examination I found it to be an epithelioma. The stricture so completely occluded the orifice that it would not admit of the passage of several grape seeds, which were lodged above it for three weeks. The œsophagus, above the stricture, was very much dilated. The subject was extremely emaciated, and the subcutaneous fat had almost entirely disappeared. There were old pleuritic adhesions on the right side.

Yours truly, A. L. KOTZ, M.D.
Easton, Pa., Nov. 12, 1887.

NOTES AND COMMENTS.

Transient Benign Plaques of the Tongue.

But two cases of this rare disease, which is variously called lingual lichenoid, exfoliation areatæ linguæ, etc., have been reported in this country. Dr. M. B. Hartzell, of this city, states that he has had the second case under observation at short intervals for two years, and gives a somewhat detailed description of it in the *Medical News*. From a reprint of this paper it is gathered that the patient was a railroad engineer of excellent general health, weighing 175 pounds, who presented, when first examined in June, 1885, an eruption on the tongue which resembled ordinary vesicles as they are seen on mucous membrane. In a day or two this whitish elevation, having increased to the size of a pea, began exfoliating, leaving a circular patch, deprived of epithelium, surrounded by a narrow, slightly elevated white border. After the patch had increased to the size of a dime, it ceased to grow larger, and in a few days the tongue gradually assumed its normal appearance. After an interval of ten to fourteen days, during which the mucous membrane of the tongue seemed perfectly healthy, a new lesion, similar to the first one, appeared, ran the same course, and again disappeared. The eruption required from ten days to two weeks to pass through its various stages. The author

says that the disease has continued to come and go in this manner until the time of the writing of the paper, September 8, 1887. Only one plaque was present at a time, and that occupied the right side of the tongue, never crossing to the smallest extent the median line of the tongue.

Dr. Hartzell believes that the disease is entirely independent of syphilis, and that there is a causal connection between dyspepsia and the occurrence of the plaques. Local treatment seems to be without benefit, but in the case just described, the internal administration of arsenious acid in doses of $\frac{1}{10}$ of a grain, prolonged the intervals between the attacks, while at the same time the individual lesions ran a shorter course.

Death from Supposed Hydrophobia.

A man named Charles Cavanan, died at Chambers-Street Hospital, New York, Nov. 15, from the effects of a dog bite received on Oct. 8. The brain and all the internal organs were congested. The spinal cord appeared normal to the naked eye, which was matter of surprise to the examining surgeons, who expected to find considerable congestion of the cord.

Cavanan saw two dogs fighting in front of his house on Oct. 8. In endeavoring to separate the dogs he was bitten in the hand. Two other persons were also bitten by the same dog, who was supposed to be mad. A policeman shot the animal a few minutes later. Cavanan and the others immediately repaired to Chambers-Street Hospital, where their wounds were cauterized. Those who appeared at the hospital with Cavanan were George H. Neidlinger, 27 years old, and James Cullen, a lad of 15 years. Neidlinger was bitten in the leg, but not severely, the dog's teeth having to contend with his trousers and the leg of an alligator hide boot. He is at present reported as being in perfect health. James Cullen, the boy of 15, was bitten in the hand.

On Monday, Nov. 14, in the afternoon, Cavanan appeared at Chambers-Street Hospital complaining of an inability to swallow, attended by convulsions of the muscles of the throat. He conversed lucidly, but at short intervals he was seized with spasms of the muscles of the throat, accompanied by copious expectoration. He was unable to take liquid of any kind, and remedies for his relief had to be administered hypodermically. Toward the close of the afternoon it was deemed expedient to remove the patient to a private room up stairs. At this

time he was perfectly cognizant of his condition and decidedly frightened. He asked for a priest, and said that he felt that this was a "terrible death to die." At his own request he was placed in a strait-jacket.

During the recurrence of the violent spasms, which seized upon him at intervals, it became necessary to hold him, but when these passed away he was perfectly sane and gentle, even exhibiting a certain grim humor at times. It required a constant effort on the part of the patient to rid himself of the mucus which gathered in his throat, and this effort seemed to occasion him great distress. During the night the patient was seized with violent spasms, so that it was all the attendants could do to hold him down. At 6 o'clock in the morning he fell into a comatose state, and died in half an hour.

The physicians ascribe his death to asphyxia and heart failure caused by convulsions and fixation of the muscles of respiration. Some difference of opinion exists in the hospital as to whether Cavanan was really a victim of the disease known as hydrophobia. It was hinted by an official that the dead man might have exhibited similar symptoms while suffering from an aggravated attack of throat or heart trouble. Others, however, are positive in their assertions that the case was one of hydrophobia.

The Seybert Commission on Spiritualism Criticised.

After a somewhat extended review of the report of the Seybert Commission of the University of Pennsylvania, Prof. Henry Kiddle, says:

"This criticism might be extended much farther, but it is unnecessary. We have already shown that—

"1. There has been no sufficient proper compliance on the part of the Trustees of the University of Pennsylvania with the terms imposed by the founder of the Seybert Chair, and the conditions prescribed by him and agreed to by the University on the acceptance of the fund of \$60,000 bequeathed by Mr. Seybert, on the condition that the 'incumbent of the Chair,' aided or not, as he desired, by a 'Committee of the Faculty,' should make the investigations.

"2. It was a gross violation of these conditions, after the original appointment of five members of the Faculty to act as a Commission, to appoint five additional persons who were not members of the Faculty; and especially to appoint four of

these persons, not connected with the University at all, several months after the investigation had commenced.

"3. The Commission were obligated to investigate the claims of Modern Spiritualism not merely as to its phenomenal basis, but as a system of 'morals, religion, and philosophy;' and this they have not even commenced to do; but have only, in a most unfair, superficial, inconsiderate, and we might almost say irrational, manner, examined the manifestations of a few mediums, whom they have, most unjustly, according to their own record, held up to public scorn and indignation. Under such circumstances, to rush into print with conclusions so lame, imperfect, and ill founded, should subject them to the censure of every impartial and intelligent mind, as we doubt not it eventually will.

"4. They have presented to the public a series of statements, called a report, crude, imperfect, sweepingly condemnatory, and wholly unscientific, neither correctly representing the facts of their own investigation, as a Commission, nor making those distinctions and discriminations as to incidents, principles, and methods which a proper knowledge of the subject would have dictated.

"5. Their report is contradicted in many essential particulars by the minutes of their proceedings, which they have chosen to keep in the background, and away from the general reader, by inserting them in an appendix.

"6. Instead of conducting the investigation by sub-committees, whose carefully constructed reports could have been attested by the signatures of those making them, they have been guilty of the gross impropriety of presenting a report signed by ten persons, which contains statements that only three or four could truthfully attest. In this way they have misled the public, and especially the newspaper press, and given a seeming importance to their investigation and the report which they do not really possess."

William F. Jenks' Prize.

The first award, under the William F. Jenks Prize Fund of The College of Physicians of Philadelphia, will be made by the Committee, for the best essay upon "The Diagnosis and Treatment of Extra-uterine Pregnancy," as soon after January 1st, 1889, as may be practicable. Papers for competition must be written in English, and be presented by the date named. The prize

essay is to become the property of the college.

Blaud's Pills.

The British Pharmaceutical Conference recommended the following unofficial formula for Blaud's Pills:

Sulphate of iron.....	60 grains.
Carbonate of potassium.....	36 "
Sugar, in powder.....	12 "
Tragacanth, in powder.....	4 "
Glycerin.....	2½ minims.
Distilled water.....	2½ "

Reduce the sulphate of iron to fine powder, add the sugar and tragacanth, and mix intimately. Finely powder the carbonate of potassium in another mortar, and thoroughly incorporate with it the glycerin and water. Transfer this to the mortar containing the sulphate of iron, beat thoroughly until the mass becomes green and assumes a soft, pillular consistence, and divide into twenty-four pills.

Each pill contains about 1 grain of ferrous carbonate.

Dose.—1 to 3 pills.

Curious Result of the Cure of Morphinomania.

A very serious paper on morphinomania by Dr. Seymour J. Starkey, in the *Nineteenth Century*, September, 1887, contains one passage which is humorous—or pathetic, we cannot say which. In this the writer says: "I have seen a man become attached and engaged to a girl while addicted to the use of morphia, and place himself under treatment for the purpose of giving up the vice and getting married; but his love vanished with his morphia."

Dangers Attending the Treatment of Obesity.

Professor Rosenfeld (*St. Petersburger med. Wochenschrift*) argues that Vertel's method of treating obesity is not without danger. The deprivation of liquids tends to augment the relative quantity of uric acid excreted, and thereby may provoke parenchymatous nephritis, with albuminuria. Strict supervision is, he thinks, always necessary. Prescriptions relative to mountain climbing and to abstention from liquids ought to be followed with prudence by persons whose habits have previously been opposed to this regimen: they should cease the treatment immediately upon the appearance of dyspnoea, vertigo, and other symptoms indicative of cardiac incapacity. The attention of the physician ought to be directed to the heart, the stomach, and the urine.—*Druggist's Circular*, November, 1887.

Practical Points About the Urine.

Dr. William B. Canfield, in a paper in the *Maryland Medical Journal*, October 15, 1887, says:

Normal urine may vary in color from a pale yellow to a brownish black, according to its concentration. The color of the urine is a very important factor in the diagnosis at the bedside. A light clear urine (*urina spastica*) would show absence of acute fever and a possible presence of polyuria; while a dark colored urine would denote not only a fever, but might signify a variety of affections of the spleen or liver, a hearty meal, active exercise, etc. Reddish or reddish-brown urine would point to blood, black urine to the presence of the pigment of melanotic cancer (melanuria). Green or brownish-green urine would indicate bile.

Different drugs have a decided effect on the color of the urine; for example, rhubarb (chrysophanic acid), senna and santalin, make it intensely yellow, or a greenish or brownish yellow. Further, logwood, strong coffee, turpentine, carbolic acid, tar, creasote fol. *uvæ ursi*, kairin and fuchsin, all color the urine. It is not probable that the presence of albumin can be suspected by the color.

The smell of urine may best be described by saying that it is urinous. When concentrated it is strong, when ammoniacally decomposed it is still stronger, and even putrescent. It is affected by certain drugs. Turpentine gives it the odor of violets. The odor of cubebs, copaiba, sandal wood, castoreum, valerian, is imparted to urine after administration by the mouth. Also after eating certain vegetables, such as garlic, asparagus, cauliflower, etc., the urine has a peculiar smell. In diabetes mellitus it may have a sweet smell.

With reference to normal urine, it is always clear when first passed, and it shows on standing a slight cloudiness (nubecula), more noticeable in the urine of women. Microscopically a few epithelial and other cells are always present, and in the case of females, vaginal epithelium. Pathologically the presence of the earthy phosphates of lime and magnesium, of the urates, pus, mucus, blood, etc., causes cloudy urine. Normally urine is aqueous. Pathologically the presence of mucus or pus may cause it to be viscid, and chyle in the urine (chyluria), as observed in the tropics, gives it a turbid and thick appearance. The foam which normally so quickly disappears from urine may remain in the presence of sugar, albumin or blood.

Of Interest to Athletes.

Dr. Sargent, who is well known as the superintendent of physical education at Harvard College, has a very interesting paper in *Scribners' Magazine* on athletics, in which he says that relatively long limbs, with short body, full chest and small bones, will characterize the typical short-distance runner wherever he may be found. Short races (100, 200 and 440 yards) are often won by a few inches, and the value of an inch or two in a runner's stride is of the greatest importance, for, other qualifications being equal, this man is bound to be first at the goal.

The small girth of the legs of runners is often mystifying. From the girth of a muscle one gets a correct idea of its volume or transverse diameters, but learns little of its length and the extent of its contractile fibres; whereas it is the length of the muscle, and not the thickness, which is of significance to short-distance runners. Given the physiological fact that a muscle can contract about one-third of its length, it will readily be seen that the longer the muscle the greater will be the movement of the part to which it is attached. To the runner the desired movement is in the elevation of the thigh and the extension and flexion of the leg and foot. An instantaneous photograph of sprint-runners shows that the range in the movement of the limbs is very extensive—the stride of a fast walker being from 4 to 6 feet, and that of a fast runner from 6 to 8 feet. If the stature is short, it is necessary for the runner to get a greater elevation from the ground at each step in order to maintain a long stride. When this is done a relatively long lower leg is of the greatest advantage. This fact is admirably brought out in the case of Myers, the professional runner. With a height of 5 feet 7½ inches, which is a little below the mean, or 50 per cent. class, he has a length of lower leg which corresponds to a man over 5 feet 10 inches in height, a length of thigh usually found in men of 5 feet 9 inches, while the sitting height is the same as that which makes up the stature of men of 5 feet 4 inches.

—The flexibility of the English language is shown in the reply of an Irishman to a man who sought refuge in his shanty in a heavy shower, and finding it about as wet inside as out, said, "You have quite a pond on the floor."

"Yis; shure we have a great lake in the roof."—*Harper's Magazine*.

HUMOR.

—A circus show can pull more sick boys and girls out of bed than all the doctors in town.

—Scientists say that the savage has a more acute sense of smell than civilized people. When two savages get together, how they must suffer!

—One of the most successful bill collectors of Chicago makes many a difficult collection by pretending to be deaf, and making the delinquent yell his reason for not paying at the top of his voice, so that it is heard by every one in the vicinity.

—Bill Nye makes John L. Sullivan, the pugilist, say: "You will find pale and studious people that knows more about ettykett and the number of bones in the human body than I do, but if a man wants his bones pointed out, and his attention called to 'em, I can do it for him."

—Physician—"Patrick, don't you know better than to have your pig-pen so close to the house?" "An' phy should Oi not, sor?" "It's unhealthy." "Be away wid yer nonsense! Sure the pig has never been sick a day in his life."

—Small Huxleyan—"I say, mammy, dis yer friziology say if a chile hab a narm long 'nuff to reach to de sun w'en he's bawn, he done be dead'n berried seberry-five year' fo' eber he gwine feel de sco'ch." Mammy (severely)—"An'nias S'phiry Jones, shet dat ar book, 'n' go split de kindlin' 'n' rest my po' brains. 'Pears like's if too much larnin'll make me mad."

—A few months ago the startling announcement was made in the press that a peculiar insect had invaded New Jersey by the million, causing great annoyance to the natives. A German drug journal, wholly unaware, we may assume, of the ironical designation of New Jersey as "Spain," warns the German pharmaceutical public against the probable exportation of Spanish flies by the United States!—*West. Druggist.*

—A Duluth newspaper, telling of the power of the magnetic iron ore of that vicinity, says that the miners have to wear mocasins, because the ore draws all the tacks from their boots; that houses near the mines have to be built with wooden pins or bolts, because the iron draws the nails; that a wild duck that had inadvertently swallowed a few hairpins was stopped in its flight over the mines, drawn earthward, and made a

prisoner; and that persons with too much iron in their blood are so magnetized that they sleep in a trance.

Items.

—The Society of Ex-Resident Physicians of the Philadelphia Hospital organized on November 16, 1887, and elected Prof. Alfred Stillé, President. The annual banquet will be held on the first Tuesday of December.

—There were three new cases of yellow-fever at Tampa on November 14, but no deaths. There were 13 cases in the hospital. No new cases of yellow-fever were reported in Tampa, but a case was reported two miles from that place.

—The Hudson river, at Albany, was very low about the middle of November, and typhoid fever was prevalent in that city. Mayor Thacher, at the instance of the Board of Health, issued a proclamation asking all citizens, before using the reservoir water, obtained from the river, to boil it, as it is supposed to contain the germs of the disease.

OBITUARY.

Dr. W. H. Peer, who had lived in Greenpoint, N. Y., for thirty-six years, died on November 13th, at the age of sixty. He had an extensive practice and amassed a fortune, which was profitably invested in real estate. He was ill for ten days with kidney disease.

Dr. Adam C. Hoffner, of Jersey City, on a trip for his health, died November 14th, in Portland, Maine, of paralysis of the heart.

Dr. G. W. Sloane, of Philadelphia, was found dead in McCoy's Hotel, Pittsburg, November 9th. He was accidentally suffocated by gas.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Nov. 13, 1887, to Nov. 19, 1887:

Colonel Glover Perin, Assistant Surgeon-General, retired from active service, Nov. 17, 1887, by operation of law. S. O., 268, A. G. O., Nov. 17, 1887.

Capt. C. B. Byrne, Assistant Surgeon, relieved from temporary duty at Fort McHenry, Md., and will return to his proper station, Washington Barracks, D. C. S. O. 242, Div. Atlantic, Nov. 11, 1887.

First Lieutenant F. V. Walker, Assistant Surgeon, relieved from duty at Post of San Antonio, and assigned to duty at Fort Ringgold, Tex. S. O. 130, Dept. Texas, Nov. 8, 1887.

List of Changes in the Medical Corps of the U. S. Navy, during the week ending Nov. 19, 1887:

Passed Assistant P. M. Rixey, ordered to the Naval Dispensary, Washington, D. C.